

Illuminating Service Experience:

A DESCRIPTIVE ANALYSIS OF INJURY AND DEATH REPORTS FOR FIRST NATIONS CHILDREN AND YOUTH IN B.C., 2015 TO 2017

DECEMBER 2020



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Cover art: "The Journey"

By Jaidyn

Jaidyn (Jay) is Cree and Métis and is originally from Nanaimo, B.C. He has lived on Vancouver Island all of his life. He is completing his Dogwood at Royal Bay Secondary School with plans to move into horticulture studies in post-secondary. His style is influenced by many First Nation artists. Many of Jay's pieces are created digitally or with graphite and minimal coloring as he prefers things to be black and white.

"I use art as a way to show who I am as a person, to represent my journey and share my passions, hopes and dreams. As a First Nations youth who grew up in the care of the Ministry of Children and Family Development, I felt lost for many years while disconnected from my roots. Over the past seven years, I have re-connected with my family and began a journey in discovering who I am.

Discovering my roots and my culture has given me a greater understanding of the connections I've always had to nature and the beauty that surrounds us. I continue to grow and give back to the community by teaching about our native history, specifically about native plants and our ability to live off the land.

I named this piece "The Journey" because it represents my journey of discovering who I am: my culture, passions and dreams as I move forward in this journey. The dream catcher represents my hopes and dreams as I discover the endless possibilities this world has to offer.

The trees and plants represent my culture, my roots and a connection to all the natural beauty that surrounds us. I also have a spiritual connection to the earth and our land; it speaks to me through nature. It reminds me to take care of this land and appreciate all that it provides us. The symbol underneath the dream catcher is a symbol for Dragons and my interest in writing and the creation of fictional worlds. The mountains represent the growth of my culture as I continue to discover my identity and the moon and starry sky represent the ever-expanding world of possibilities."

Dec. 8, 2020

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Illuminating Service Experience: A Descriptive Analysis of Injury and Death Reports for First Nations Children and Youth in B.C., 2015 to 2017* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 6 (1)(c) of the *Representative for Children and Youth Act*.

Sincerely,



Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Kate Ryan-Lloyd
Clerk of the Legislative Assembly
Susan Sourial
Committee Clerk, Legislative Assembly

The Representative and staff, who do their work throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nation peoples of British Columbia. We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George), the Songhees and Esquimalt Nations (Victoria), and the Musqueam, Skwxwu'7mesh, Tsleil-Waututh and Kwikwetlem Nations (Burnaby) where our offices are located.

We would also like to acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

Contributors

The Representative would like to acknowledge with gratitude the First Nations leaders, community members and service providers who shared their wisdom and insights with us for this report.

The Representative would also like to thank the following staff and consultant who contributed to this report.

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Executive Summary

Illuminating Service Experience: A Descriptive Analysis of Injury and Death Reports for First Nations Children and Youth in B.C., 2015 to 2017, is the second report from the Representative for Children and Youth (RCY) using a new and collaborative way to research and inform. The sister report to this one, *Invisible Children: A Descriptive Analysis of Injury and Death Reports for Métis Children and Youth in B.C., 2015 to 2017*, was released in July 2020.

This report is the result of an aggregate review that looked at injury and death data over a three-year period. It focuses on injuries and deaths reported for children and youth identified by the Ministry of Children and Family Development (MCFD) as First Nations, and uses injuries and deaths reported for non-Indigenous children and youth as a comparison group. Although the intent of examining aggregate data is to help prevent similar tragedies in the future and to inform improvements to services, this report breaks new ground by doing this work in a different way.

At the heart of the Representative's intention with this report is the desire to produce research that is directly useful to the communities affected. Too often since colonization, research relationships – broadly speaking – have been unequal, and research produced has not always been helpful for the communities involved. With this report, the Representative intentionally aims to disrupt that trajectory and work in collaboration with First Nations communities to produce what they have said they need. The Representative acknowledges that the privilege of possessing such data comes with significant responsibilities, including the responsibility to share with the communities from which it is drawn in ways that are most useful to them and to help those communities' efforts to improve services for their children and youth.

This is particularly crucial since, on Jan. 1, 2020, the federal *Act respecting First Nations, Inuit and Métis children, youth and families* came into force. As First Nations, Métis, Inuit and Urban Indigenous peoples prepare to resume jurisdiction over their own child welfare systems, the Representative is committed to continuing to grow this type of collaborative practice, and to ensuring that the Office serves a purpose that is clearly and directly of use to and supportive of these communities.

For this report, RCY staff conducted preliminary analyses, such as an overview of injury types and basic demographics, and then shared these with First Nations child-serving organizations and leadership. Those groups included the First Nations Leadership Council representing the First Nations Summit, the Union of B.C. Indian Chiefs and the B.C. Assembly of First Nations, the Delegated Aboriginal Agencies Directors Forum and several Delegated Aboriginal Agencies and service providers. In addition, a presentation was made at the All Chiefs meeting in 2019. These meetings guided and informed the direction of this report. It is the Representative's hope that these meetings and conversations will be ongoing.

Not surprisingly, there was not always consensus between groups in their reactions to the data. Questions posed varied, as did requests for further analysis, illustrating the complexity of needs and experiences across the province. Some of the areas First Nations leaders were interested in that are reflected in this report included concerns around mental health services, cultural interventions or traditional approaches to wellness in response to injuries and deaths, concerns about Urban Indigenous youth and their needs, transition planning and a lack of supports for youth transitioning out of care, and concerns about the complex needs of some young people and the lack of services for them.

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A common theme throughout RCY consultations with First Nations leaders, community members and service providers was curiosity about supports for those not in care. Keeping children and youth with family was a priority for many and a need for more support services and regular contact with supports was identified. Often, consultations identified poverty as a pressing concern for families. While there are likely myriad reasons that few injuries were reported for children and youth not in care, the Representative is concerned about this cohort.

The data examined for this report found 87 deaths and 1,067 injuries reported for First Nations children and youth. Additionally, 200 Care Plans of First Nations youth with reported injuries were explored to examine issues important to First Nations leadership, service providers and community members. The Representative noted the following from the data:

- one-third of deaths reported for First Nations children and youth were unexpected (due to accident, suicide, or homicide)
- most injuries reported for First Nations youth were for female-identifying youth
- injuries reported for First Nations youth were most commonly reported for those placed in foster homes
- injuries were most commonly reported for older youth
- sexual assaults and suicide attempts were most commonly reported for both First Nations children and youth and non-Indigenous children and youth
- physical assault injuries and caregiver mistreatment were reported more commonly for First Nations children and youth than non-Indigenous children and youth
- substance-related injuries were more commonly reported in large or medium-sized population centres
- there were different patterns of injuries reported for those in small urban or rural population centres as compared to medium and large population centres, possibly reflecting differences in access to services
- thirty-five per cent of First Nations children and youth included in our stratified random sample were from Nations outside of B.C.

The majority of injuries reported for First Nations children and youth were for those in the care of MCFD or a Delegated Aboriginal Agency. The highest number of injuries were reported for First Nations children in permanent care under a Continuing Custody Order (CCO). There was a striking difference in the number of injuries reported for First Nations and non-Indigenous children who were CCO. More than two times the number of injuries were reported for First Nations children and youth who were CCO than non-Indigenous children and youth who were CCO. The Representative is troubled by this statistic.

The Representative's Care Plan analysis indicated that some First Nations children and youth with injuries may not be supported to access all the services they need to thrive. Many of the children and youth included in the Care Plan analysis had one or more confirmed mental health concerns. It was heartening to see that many children and youth were accessing some mental health supports but only four per cent of the sample were noted to be accessing Aboriginal Child and Youth Mental Health services. Further, only five per cent of the sample had documented access to traditional healing or Indigenous mental health practices.

Another notable finding from the Care Plan analysis was that in nearly half of the cases (46 per cent), no evidence could be found that the child or youth's Nation was involved or informed that they were in care. Further, there appears to be a pattern around involvement of a child or youth's Nation when these Nations are located outside B.C. These young people were less likely to have their Nations involved or informed.

Although this report considers injury and death data, the Representative wishes to highlight that the children and youth reflected in this report are far more than the data might suggest; that is to say, they are not defined by what has happened to them. The Representative and her staff recognize that the data represents real young people with hopes, dreams, gifts and aspirations. They are much more than the harms and trauma they have undergone.

This report is offered to provide First Nations leadership and service providers with more information to inform and support their work, particularly on resumption of child welfare jurisdiction. The Representative commits to sharing future aggregate data in consultation with the parties to – as best as possible – address their issues of interest.

Introduction

An Opportunity to Support First Nations Resumption of Jurisdiction of Child Welfare

This report was imagined during a confluence of several factors in late 2017 to mid-2018. The over-involvement of the child welfare system in the lives of Indigenous children is seen in the critical injuries and deaths that are reported to the Representative.^{1,2} This over-involvement is well documented and has been the subject of significant national and provincial concern.^{3,4} Census 2016 data notes that while nearly eight per cent of the child population in Canada is Indigenous (7.7 per cent), 52.2 per cent of children in foster care are Indigenous (Government of Canada, 2020).⁵ Over a year has passed since the government released the National Inquiry's *Final Report into Missing and Murdered Indigenous Women and Girls (MMIWG)* without substantive progress on addressing many of the recommendations relevant to child welfare.⁶ The findings of the 2015 Truth and Reconciliation Commission confirmed the over-involvement of the child welfare system in the lives of Indigenous children to be at a “crisis level”.⁷ Prior to this, internationally, in 2012, the United Nations Committee on the Rights of the Child recommended that Canada take urgent measures to address “the discriminatory over-representation” of Indigenous children in “out-of-home” (foster) care.⁸

Up to 2018, the Representative prepared Critical Injury and Death (CID) Updates that reported injury and death data for every four-month period.⁹ In 2018, the final CID update was published, and work

¹ While the number of Indigenous children and youth in care is reported to be down, the over-involvement of the child welfare system in Indigenous family life remains. Further, the number of Indigenous children and youth in care remains disproportionate.

² It is preferable to refer to Indigenous peoples as specifically as possible or at least by First Nations, Métis or Inuit. The umbrella term, Indigenous, is used to refer to all those people who have lived on Turtle Island (North America) for time immemorial.

³ Grand Chief Ed John, *Indigenous Resilience, Connectedness and Reunification – From Root Causes to Root Solutions: A Report on Indigenous Child Welfare in British Columbia*, 2016, <http://fns.bc.ca/wp-content/uploads/2017/01/Final-Report-of-Grand-Chief-Ed-John-re-Indig-Child-Welfare-in-BC-November-2016.pdf>.

⁴ West Coast Leaf, *Pathways in a Forest: Indigenous Guidance on Prevention-Based Child Welfare* (Vancouver: West Coast Leaf), 2019, <http://www.westcoastleaf.org/wp-content/uploads/2019/09/Pathways-in-a-Forest.pdf>.

⁵ Government of Canada, “Reducing the number of Indigenous children in care,” First Nations Child and Family Services, last modified Aug. 19, 2020, <https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851>.

⁶ Kendall Latimer, “Lack of progress 1 year after MMIWG report ‘disheartening,’ says Sask. teen,” *CBC Online*, June 5, 2020, <https://www.cbc.ca/news/canada/saskatchewan/sask-mmiwg-awareness-one-year-anniversary-reportx-1.5600369>.

⁷ Linda McKay-Panos, “Over-Representation of Indigenous (and other Racialized) Children in the Child Welfare System: Human Rights Aspects,” *LawNow. Relating law to life in Canada*, Aug. 31, 2018, <https://www.lawnow.org/over-representation-of-indigenous-and-other-racialized-children-in-the-child-welfare-system-human-rights-aspects/>.

⁸ United Nations, “Concluding observations on the combined third and fourth periodic report of Canada, adopted by the Committee at its sixty-fifth session (17 September – 5 October 2012),” Dec. 6, 2012, <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsh8%2FU426pHwccUxzN5kmnhLtdnrWm1hJzGwfrOtSF7im%2Btj4%2BJ5n5CPlpIDWXA35DpHXskxTdDvCoa0RW9yOJTACORYOJ17Auf%2Bpplgz6CB>.

⁹ In 2020, the Representative's Critical Injury and Death – Reviews and Investigations program area shortened its name. It is now known as Reviews and Investigations.

began to identify other opportunities to disseminate information on critical injury and death trends. At that time changes were made to how injury and death data was coded.

One vital change was the ability to disaggregate Indigeneity by First Nations, Métis and Inuit. This enabled the Representative to consider young people and their families not as one homogenous group of Indigenous peoples but to look more carefully at issues for First Nations, Métis and Inuit young people and their families. The Representative hopes that this ability will facilitate further qualitative analysis of the over-representation of Indigenous children and youth in the child welfare system. The Representative intends that, in keeping with Indigenous research methodologies, RCY's collection, use and reporting of data will demonstrate a commitment to relationship, respect, relevance, responsibility, reciprocity and repair with First Nations, Métis and Inuit communities.¹⁰

With regard to data, far too often First Nations, Métis and Inuit peoples, broadly speaking, are subjects of research and reporting without consideration of the uniqueness of each group and without their involvement in the research. The sister report to this one, entitled *Invisible Children* and released in July 2020, purposely considered only Métis children and youth and was informed by the wishes of Métis service providers and leadership. This report is offered in the same spirit. It is meant to support First Nations leadership and service providers in having more information to inform and support their work on resumption of child welfare jurisdiction. The Representative commits to sharing aggregate data – in accordance with her legislation, the *Representative for Children and Youth Act* – to address the questions and issues of interest and importance to First Nations, Métis, Inuit and Urban Indigenous peoples.¹¹

New Directions

When Jennifer Charlesworth began her tenure as the third Representative for Children and Youth in October 2018, she directed researchers to immediately reach out to service providers and First Nations leaders to have conversations about the critical injury and death data held by the Representative concerning First Nations children and youth. The Representative wanted her analyses of the data to be informed by the interests and requests of First Nations service providers and leadership. It was here, in these relationships, that this report took shape. During the final stages of research, *An Act Respecting First Nations, Inuit and Métis children, youth and families* (formerly *Bill C-92*) came into force on Jan. 1, 2020 that enables First Nations, Métis and Inuit governments to resume jurisdiction and exercise their inherent rights to look after their own children, youth and families. The First Nations Leadership Council (FNLC) has been directed by resolution from First Nations to wholly reform the current Indigenous child welfare system in B.C., including working with federal and provincial governments to develop First Nations-supported legislation, policies and practices that recognize and affirm Indigenous child welfare systems.¹² The Representative recognizes the inherent rights and

¹⁰ Originally described as the Four R's by Kirkness and Barnhardt (2001), it includes respect, relevance, reciprocity, and responsibility. The fifth R of relationships was added over time in works such as those by Harris and Wasilewski (2004), Restoule (2008), and Styres and Zinga (2013) and is consistent with the direction that the Representative wanted to take with any work that engages youth, family members, community members, external stakeholders and partners. RCY has added a 6th R – repair – to address the need for the Office to be actively engaged in reconciliation.

¹¹ *Representative for Children and Youth Act*, SBC 2006, current to Nov. 11, 2020, https://www.bclaws.ca/civix/document/id/complete/statreg/06029_01.

¹² The First Nations Leadership Council is comprised of the political executives of the British Columbia Assembly of First Nations, First Nations Summit and the Union of British Columbia Indian Chiefs. This group works together to develop coordinated approaches to issues relevant to First Nations communities throughout the province.

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responsibilities of First Nations peoples with respect to the safety and well-being of their own children and youth. In support of this, a Memorandum of Understanding (MOU) between RCY and the FNLC commits the parties to a respectful and ongoing relationship to collaborate on issues relating to the safety and well-being of First Nations children and youth.¹³

The Representative and the Delegated Aboriginal Agencies (DAAs) Directors Forum have also been developing a joint commitment agreement to enhance information sharing and consultation on matters of shared interest and concern respecting the well-being and safety of First Nations, Métis, Inuit and Urban Indigenous children and youth.

In accordance with the respect that underlies these agreements, the intention is that the data and analysis that follows will support the FNLC, First Nations, DAAs and other organizations in working towards the reduction of the over-involvement of the colonial child welfare system in the lives of their children and youth and provide evidence that reinforces the importance of supporting First Nations children, youth, their families and communities.

Purpose of the Report

This report aims to explore themes related to injury and death reports for First Nations children and youth who are receiving reviewable services.¹⁴ While the Representative's provincial and territorial counterparts have produced statistical reports on critical injuries and deaths (e.g., Alberta's *Summary Report – Five Years of Investigations – April 1, 2012 – March 31, 2017* and Ontario's *Serious Occurrence Reports*), First Nations-specific data have not been disaggregated for Indigenous children and youth (i.e., specific to First Nations, Métis, and Inuit).^{15, 16} As the *Act Respecting First Nations, Inuit and Métis children, youth and families* has come into force, the Representative wishes to support communities in resuming jurisdiction for child welfare. To that end, this data is presented to leadership, community members and service providers as they plan the support systems that will uphold their traditional laws. Additionally, this report is presented to the public as part of the Representative's function to review and report on critical injuries and deaths of children.

In order to determine what data would be useful, the Representative's staff met with the Delegated Aboriginal Agency Directors Forum, the FNLC and with six DAAs.¹⁷ The DAAs serve approximately

¹³ The Delegated Aboriginal Agencies Directors Forum is comprised of leaders from the 24 DAAs located around the province. The DAAs have various levels of delegation: three can provide voluntary services and recruit and approve foster homes; seven have the additional delegation necessary to provide guardianship services for children in continuing care; and 14 have the delegation required to provide, in addition to the above, full child protection, including the authority to investigate reports and remove children. Two DAAs have Adoption Delegation as well. These DAAs provide services to approximately two-thirds of the over 200 First Nations in B.C.

¹⁴ Reviewable services are defined in the *RCY Act* as those provided under the *Child, Family and Community Service Act* and the *Youth Justice Act*; publicly funded mental health services for children, addiction services for children or another government service, as directed by the Lieutenant Governor in Council. For further detail see Appendix B: Methods.

¹⁵ Office of the Child and Youth Advocate of Alberta, *Summary Report: Five Years of Investigations, April 1, 2012 – March 31, 2017* (Edmonton, AB: Office of the Child and Youth Advocate of Alberta), 2018, <http://www.ocya.alberta.ca/adult/news/summary-report-five-years-of-investigations/>.

¹⁶ Provincial Advocate for Children and Youth and Kim Snow, *Serious Occurrences Report: Preliminary Report* (Toronto, ON.: Office of the Provincial Advocate for Children and Youth), 2016.

¹⁷ The Representative invited DAAs to meet with her team and six were able to do so individually while others were able to engage at the DAA Director's Forum.

121 of the 204 B.C. First Nations as well as the majority of Métis and Urban Indigenous populations in B.C. The Representative and project team members also made a presentation to the All Chiefs Meeting on Children and Families in October 2019.¹⁸ During these meetings, RCY analysts provided some initial data and analyses and requested feedback, which was generously offered by many participants. The Representative is committed to continuing to hear from and work with First Nations, DAAs and non-DAA affiliated communities to inform her work. The Representative recognizes that there remains much work to do to determine how to respectfully share meaningful information that is relevant to their aims to enhance child and youth well-being and reduce the over-involvement of the child welfare system in the lives of children and families.

There was not always consensus between groups in their reactions to the data. Questions posed and requests for further analysis varied, reflecting the complexity of needs and experiences across B.C. However, in these conversations with First Nations leadership, communities and agencies, some shared questions, concerns and interests emerged. Within the limits of the information available through injury and death reports, the Representative attempted to address the questions and concerns.¹⁹ Additionally, some analyses and results were removed after hearing from community members and service providers that these may result in unintended harms to young people.

To address some of the questions and concerns, analysts went beyond the injury and death reports and conducted a review of electronic records for a sample of 200 children and youth with injuries. Beginning in 2021, a series of reports out of the Representative's review of care planning for all children and youth in the care of the Ministry of Children and Family Development (MCFD) will be released. This work will qualitatively address many of the questions posed to her during these consultations. What follows is offered as an invitation to what might be useful for First Nations leadership, communities and agencies to inform them of what is being reported to the Representative by way of injury and death reports and how this can be disaggregated.

Review of Care Planning: Foreshadowing Other Work of the Representative

RCY is currently conducting a qualitative review of care planning for children and youth in the care of MCFD, including First Nations, Inuit and Métis children and youth. One focus of the review is a text analysis of multiple Care Plans within a child's file to determine the year-to-year progress. In addition, in-depth interviews are being conducted with key players within the care planning process, including guardianship workers, caregivers and children and youth. While a point-in-time analysis of a Care Plan provides a detailed look at a child's in-care experience, a longitudinal look at multiple Care Plans over a period of a child's time in care provides greater potential to identify systemic trends in the practice of guardianship. The overarching goal is to develop recommendations that will improve the quality of care planning for all children in care.

¹⁸ The objective of this meeting was to bring together Chiefs, leaders and experts to discuss *An Act Respecting First Nations, Inuit and Métis children, youth and families*, and the implications for First Nations in British Columbia.

¹⁹ Limitations of the current data are outlined in Appendix B. Despite these limitations, the Representative believes there is valuable information that communities can use as they plan services and supports for children, youth and families.

Introduction

Questions and concerns that are considered within this report:

- concern about mental health services under the Aboriginal Child and Youth Mental Health umbrella and whether these services are culturally appropriate
- questions about cultural interventions or traditional approaches to wellness and healing in response to injuries and deaths
- concern about Urban Indigenous children and youth and their specific needs
- concern about transition planning and aging out of care and the lack of supports
- concern about the complex needs of some young people and the lack of appropriate services.

Questions and concerns that were beyond the scope of this report:²⁰

- whether there is a relationship between cultural planning and injuries and deaths
- questions about supports and services in rural/remote communities
- querying prevention services and any possible link to injuries and deaths.

Background and Intentions

Analysts work daily with data at the office of the Representative for Children and Youth to fulfill the legislative mandate to help inform improvements to child welfare, mental health, addictions and youth justice services for children, families and youth. Specifically, within the work of the Reviews and Investigations team, researchers are working to better understand systems and structures that fail to meet the needs of children and youth in order to prevent similar injuries and deaths. Each researcher brings their own story and background to this work. Appendix A describes the lenses and methodologies used by the researchers.

Many of the methods used to describe and analyze the data are outlined in detail in Appendix B. The Representative and her staff recognize that these records represent sacred stories of young people and their families. RCY researchers approached the data carefully, recognizing the challenge of describing data that often details individual circumstances and the inherent risk of pathologizing the children and youth rather than contextualizing their experiences within a system. RCY researchers recognize that they review data in which children and youth are described based on their injuries and deaths rather than the fullness of their lives. Care was – and is always – taken to avoid pathologizing the children and instead to consider how systems may have contributed to their circumstances.

Quantitative methods typically decontextualize Indigeneity and many statistics describing Indigenous peoples fail to critically evaluate the societal structures that perpetuate negative stories of Indigenous children, families and communities.²¹ This is particularly challenging when considering that these types of datasets are often deficit-focused and can reinforce stereotypes of Indigenous life. It is the Representative's intention to focus on the systems that fail to protect children and youth or place them in harm's way.

²⁰ These questions and concerns will be taken into account as the Representative determines future data sharing and project priorities.

²¹ Nichole M. Garcia, Nancy López and Verónica N. Vélez, "QuantCrit: Rectifying Quantitative Methods Through Critical Race Theory," *Race, Ethnicity and Education* 21, no. 2 (2018): 149-157.

Indigenous Child Welfare and Jurisdiction: Stories and Shifting Landscapes

“The child welfare system... function(s) from the inherent fundamental belief that we as parents in our own communities do not have the right to birth, raise, educate, discipline and protect our children from Canada’s inherent racism.” – Senator Murray Sinclair

The welfare of children, youth and families is vital to a society. In most instances, families care for one another and in more modern times in Eurocentric nations, the responsibility and care for children and youth rests on parents or a parent. Where a parent or parents need support to parent or where other kin need this support, the state provides support to varying degrees through the provinces and territories. In cases where children and youth are unsafe, the various provinces and territories have jurisdiction for child welfare. In the Canadian context, residential schools, colonialism and the ongoing removal of First Nations, Métis and Inuit children and youth from their homes, families and communities continues to significantly disrupt First Nations, Métis and Inuit family and community life.

In January 2018, in response to the Truth and Reconciliation Commission (TRC) Calls to Action and the significant criticism of the number of First Nations, Métis and Inuit children and youth in foster care, the then federal Minister of Indigenous Services Jane Philpott, called an Emergency Meeting on First Nations, Inuit and Métis Nation Child and Family Services. Minister Philpott named the “crisis” and detailed the “severe over-representation of Indigenous children in foster care.”²² The first five Calls to Action of the TRC specifically address child welfare with the fourth calling upon the federal government to enact Aboriginal child-welfare legislation that affirms Aboriginal inherent rights to “establish and maintain their own child-welfare agencies.”²³

In B.C., child welfare legislation and therefore jurisdiction for child welfare has rested with the provincial government via the Director of Child Welfare. Splatsin First Nation challenged the provincial government in court attempting to assert jurisdiction over their children in 2015 in response to MCFD’s assertion of jurisdiction.²⁴ The TRC’s findings clearly indicated that while residential schools no longer operate, the child-welfare system continues the assimilation that residential schools started, a practice that Splatsin have worked hard to disrupt. First Nations, Métis and Inuit children and youth have been included in the *Child, Family and Community Service Act (CFCS Act)* that details MCFD’s authority for B.C. child welfare. The *CFCS Act* sets out the circumstances in which child welfare practitioners become involved in the lives of First Nations, Métis and Inuit children and youth in B.C. to keep them safe. In some cases, the removal of these children and youth from their family home is deemed necessary. In these cases, MCFD or a DAA assumes the care of children and youth, along with the duty to protect them from harm.

²² Government of Canada, “Speech of Minister Jane Philpott at the Emergency Meeting on First Nations, Inuit, and Métis Nation Child and Family Services,” 2018, <https://www.canada.ca/en/indigenous-services-canada/news/2018/04/emergency-meeting-on-first-nations-inuit-and-metis-nation-child-and-family-services.html>.

²³ Truth and Reconciliation Commission of Canada, *Truth and Reconciliation Commission of Canada: Calls to Action* (Winnipeg, MB: Truth and Reconciliation Commission of Canada), 2015, p. 1.

²⁴ Sunny Dhillon, “B.C. First Nation Sues Province over Child Welfare Bylaw,” *Globe and Mail*, Oct. 13, 2015, <https://www.theglobeandmail.com/news/british-columbia/bc-first-nation-sues-province-over-child-welfare/article26795272/>.

The Representative believes the use of data is an important aspect of effecting systems change. In her report, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*, Kasari Govender, B.C.'s Human Rights Commissioner shares how vital the collection of disaggregated data can be. "Rather than monitoring the lives of our citizens, collecting and using disaggregated data is about caring for our communities by informing law, policy and institutional practice that is in service of — and developed in collaboration with — those who are systemically discriminated against."²⁵ The Representative intends that the data description that follows be used to support shifting child welfare practice including resumption of jurisdiction under *An Act Respecting First Nations, Inuit and Métis children, youth and families*.

In these changing times, the Representative has also heard about the unique challenges that Urban Indigenous children and youth face. Many children and youth are living in urban centres and many are from First Nations that are outside of B.C. To this end, staff have considered their context in the analyses that follow.

Unique Context: Urban Indigenous Children and Youth

The *Indian Act* (1876) enshrined in legislation the idea of moving Indigenous peoples from their land to make space for settlers starting in the late 1800s.²⁶ In addition, historically and presently, the *Indian Act* remains a powerful tool for determining who has status and who does not, dividing families, communities and Nations by way of identity and relationship to traditional territories.²⁷ The effects on cultural identity for children, youth and their families by the Canadian government and its agencies remain profound. While traditional lifestyles and connection to ancestral homelands remain important factors in Indigenous identity, for Urban Indigenous children and youth, this can further exclude them from land-based cultural connections that may be so removed from their urban experiences.²⁸

DATA SNAPSHOT: Canada

- 2016: almost 900,000 Indigenous people lived in urban areas accounting for more than half of the Indigenous people in Canada*

DATA SNAPSHOT: B.C.

- B.C. has the second largest First Nations population in Canada*
- In B.C., 78 per cent of First Nations, Métis and Inuit peoples are living, studying and working in urban and off-reserve areas **

Sources:

- * J. Caldwell, "Learning, Doing, Listening," *BCcampus*, Dec. 6, 2019, <https://bccampus.ca/2019/12/06/indigenization-guideurban-indigenous-peoples-and-demographics/>.
- ** Government of British Columbia, "Urban and Off-Reserve Aboriginal People, *Supporting Communities*, n.d., <https://www2.gov.bc.ca/gov/content/governments/indigenous-people/supportingcommunities/urban-off-reserve-aboriginalpeople>.

²⁵ British Columbia Office of the Human Rights Commissioner, *Disaggregated demographic data collection in British Columbia: The grandmother perspective* (Vancouver, B.C.: British Columbia Office of the Human Rights Commissioner), 2020, 6.

²⁶ B.W. Morse, *Aboriginal Peoples and the law: Indian, Métis and Inuit rights in Canada* (Ottawa: Carleton University Press, 1985).

²⁷ Elizabeth Fast, Marie-Ève Drouin-Gagné, Nahka Bertrand, Swaneige Bertrand and Zeine Allouche, "Incorporating diverse understandings of Indigenous identity: toward a broader definition of cultural safety for urban Indigenous youth," *AlterNative* 13, no. 3 (2017): 152-160.

²⁸ Evelyn Joy Peters and Chris Anderson, *Indigenous in the City: Contemporary Identities and Cultural Innovation* (Vancouver: UBC Press, 2013).

Wawmeesh Hamilton reports that Urban Indigenous people face challenges of recognition and having their voices heard when living off-reserve.²⁹ “No land, no interests,” describes the feelings of those Urban Indigenous people with regard to their rights to self-determination while living in an urban context.³⁰

More than half of the Indigenous people in Canada live in urban areas.³¹ Vancouver has a large Urban Indigenous population and one of the largest Indigenous child-serving organizations delegated to provide child welfare services in Canada. Both staff and youth from the Vancouver-based DAA, Vancouver Aboriginal Child and Family Services Society, shared with the Representative the struggles they face with recognition as Urban Indigenous youth. The *Urban Aboriginal Peoples Study, Vancouver Report*, notes that 63 per cent of those Indigenous people who live in Vancouver consider it their home while 21 per cent consider their community of origin home and 15 per cent consider another community home.³² While researchers have historically drawn attention to the loss of culture for Urban Indigenous people in some urban areas, strong Indigenous pride remains and continuing cultural connections are nonetheless occurring.

Cultural safety in an urban context across the province must consider cultural losses that Urban Indigenous youth experience as a result of historic and ongoing colonialism. At the same time, “support for youth who wish to reconnect with and reclaim their Indigenous culture(s) in the city” must be encouraged.³³ Space must be made for Indigenous youth with diverse and complex identities to become visible and advocates must work towards representation of the interests of Urban Indigenous youth at the highest policy-making levels. To this end, the Representative will consider a geographic description of the data in this report through analysis of urban and rural contexts and explore whether differences exist.

²⁹ Wawmeesh Hamilton, “Urban Indigenous people forgotten in UNDRIP talks, say advocates,” *CBC News*, Jan. 26, 2020, <https://www.cbc.ca/news/canada/british-columbia/urban-indigenous-undrip-1.5436278>.

³⁰ Hamilton, *CBC News*, 2020.

³¹ Urban areas are defined here as towns and cities in which the population exceeds 30,000.

³² *Urban Aboriginal Peoples Study: Vancouver Report* (Toronto: Environics Institute, 2011), <https://www.uaps.ca/wp-content/uploads/2010/02/UAPS-Vancouver-report.pdf>.

³³ Fast et al., “Incorporating diverse understandings,” 156.

Methodology

Brief Methods Description

Critical injuries and deaths are reported to the Representative when children, youth and/or their families are receiving government services or when they received services within the 12 months prior to the injury or death.³⁴ When reports are received, analysts categorize these within one of eight injury types or one of five death types.³⁵ The Representative uses information on critical injuries and deaths of children and youth receiving reviewable services to identify patterns and recommend systemic reforms.

For this report, those critical injuries and deaths reported to the Representative between Jan. 1, 2015 and Dec. 31, 2017 were included in analyses. This report focuses on injuries reported for children and youth identified by MCFD as First Nations, and uses injuries and deaths reported for non-Indigenous children and youth as a comparison group.³⁶ MCFD practitioners do not reliably report ethnicity for any children and youth in the non-Indigenous category; therefore, racialized children and youth are included in the non-Indigenous category.³⁷

Children and youth were identified as First Nations or non-Indigenous using MCFD's electronic records. Some children and youth have multiple identities (e.g., a child or youth may have both First Nations and Métis heritage) and in these cases, only one identity was recorded.³⁸ The Representative recognizes this as a limitation of the current analysis but believes that the results accurately describe some important themes and trends.

Descriptive data is presented as frequency counts and percentages. Some comparisons are analysed using the chi-square statistic.³⁹ Significant differences between comparisons are denoted in graphs with an asterisk (*).

³⁴ Specific government child- and family-serving systems, referred to as reviewable services, are mandated to report critical injuries and deaths. Appendix D provides definitions of reviewable services, as well as critical injuries.

³⁵ See Appendix D for definitions and Appendix B for methods of conducting initial reviews of injury and death reports.

³⁶ Currently, non-Indigenous is the only coding available to capture those children and youth who are not First Nations, Métis or Inuit. The Representative can code for ethnicity and race; however, service providers do not code for this in the injury and death reports. This is a significant limitation and results in the disappearance of racialized experiences within the data set. In the RCY report, *Caught in the Middle*, released in November 2019, the Representative recommended that MCFD record each child's self-identified ethnicity in the ministry's case management system (recommendation 4). This recommendation has not yet been implemented.

³⁷ The Commission on Systemic Racism in the Ontario Criminal Justice System, 1995, describes racialization as "the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life." This is typically a negative process resulting in racial inequalities that are embedded within social structures and systems.

³⁸ RCY's case management system, CITAR, allows only one identity to be coded. In cases in which children and youth were noted to have more than one identity, RCY staff used electronic records and Care Plans to determine what identity the child or youth most identified with or, if that was unknown, the identity assigned by ICM to the child or youth's mother.

³⁹ Chi-square tests determine whether significant differences exist between observed frequencies for different variables. For example, if there was no effect of gender on the number of sexual assaults reported, it would be expected that there would be relatively equivalent numbers of sexual assaults reported for female and male youth. If the numbers of sexual assaults reported for female and male youth are significantly different than those expected values, it can be said that gender may influence sexual assaults. Significant differences between these expected frequencies and observed frequencies in the table are determined based on p -values $< .05$. Effect sizes were calculated using Cramer's V.

Some areas of analysis, as described in the section that follows, were added after consultation with the First Nations Leadership Council and service providers. The Representative's intention is to point to the system of care and facilitate planning systems of support for First Nations children and youth. Leaders and service providers identified issues for First Nations children and youth from their perspectives, as well as those variables that would be of interest in monitoring future programming and service delivery. RCY staff conducted preliminary analyses, such as an overview of injury types and basic demographics, and then shared these with First Nations child-serving organizations and leadership. During consultations, they shared feedback on initial analyses and made requests for further descriptions. Some consultations identified a need to explore injury data for children and youth receiving MCFD or DAA support, but who were not in care. Other areas of analysis were revealed as analysts worked with the data and are offered as potentially informing future service delivery to First Nations youth.

For some questions that arose through consultation, a more in-depth review of records was required.⁴⁰ Therefore, a stratified sample of 200 First Nations children and youth in care was selected from the total injury and death reports received between January 2015 and December 2017 for First Nations children and youth. Stratified random sampling is a method that involves the division of a population into smaller groups known as strata. In stratified random sampling, the strata are formed based on shared characteristics.⁴¹ The benefit of this technique is that there is increased confidence that the sample represents the population. While it would have been very difficult to conduct a robust analysis of the electronic records of all First Nations youth with reported critical injuries between 2015 and 2017, conducting this analysis of 200 that represent the full population sheds insight into the strengths and challenges of the youth and the systems that serve them. In this case, the variables used to generate the stratified sample were gender, age and placement type. The children and youth included in the sample are described in Table 1.

⁴⁰ This record review is also undertaken when injuries are first reported for children and youth, but this review of records had a more specific purpose.

⁴¹ Kenneth S. Bordens and Bruce B. Abbott, *Research Design and Methods*, 6th ed. (Boston: McGraw-Hill, 2005), 252.

Methodology

Table 1. Characteristics of stratified random sample of First Nations youth with reported critical injuries

| | Female | | | | Male | | | | GD ⁴² | Total |
|------------------------|--------|------|-----|----|-------|------|-----|----|------------------|-------|
| | 13-18 | 6-12 | 1-5 | <1 | 13-18 | 6-12 | 1-5 | <1 | 13-18 | |
| Foster Home | 44 | 28 | 8 | 0 | 20 | 14 | 8 | 1 | 3 | 126 |
| Staffed Resource | 22 | 2 | 0 | 0 | 12 | 4 | 0 | 0 | 0 | 40 |
| Family Home | 6 | 4 | 0 | 0 | 4 | 1 | 1 | 0 | 0 | 16 |
| Restricted Foster Home | 2 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 5 |
| Custody | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Shelter | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| On Own | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| Homeless | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 3 |

For each child or youth included in this smaller sample, a review of MCFD's electronic record system was carried out.⁴³ Variables of interest were identified through consultations and included:

- reviewable service areas that were involved
- identified mental health and developmental health concerns (confirmed or suspected)
- the number of placements that children and youth had lived in
- attendance at school/educational program
- whether their Nation had been notified or involved in planning, and
- types of permanency planning goals.

⁴² Gender diverse (GD) is an umbrella term to capture youth identified as those who are transgender, fluid or questioning their gender identity, Two-Spirit or who identified outside of the gender binary.

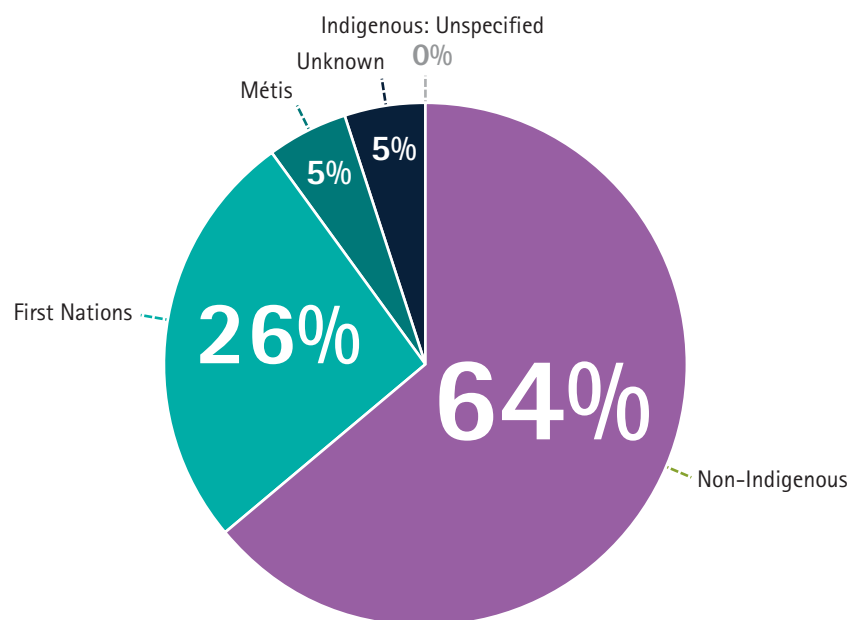
⁴³ For detailed methods of the electronic record review, see Appendix B.

Results

Overview of Death Reports

Three hundred and thirty-seven deaths were reported between January 2015 and December 2017. During the reporting period, there were 87 deaths reported for First Nations children and youth receiving services. Overall, slightly more than one in four (26 per cent) of the deaths reported to the Representative between 2015 and 2017 were for First Nations children and youth. In contrast, almost two-thirds (64 per cent) of deaths were reported for non-Indigenous children and youth (see Figure 1).

Figure 1. Percentage of deaths by Indigeneity



Age and gender

Most of the First Nations children and youth whose deaths were reported to the Representative were either infants (i.e., one year old or younger - 49 per cent) or older adolescents (i.e., aged 16 to 18 - 29 per cent). Slightly more than half of First Nations children and youth who died were female (55 per cent), while 44 per cent were male and one per cent were gender diverse. This was similar for deaths reported for non-Indigenous children and youth.

Care status and living arrangements

Most of the First Nations children and youth whose deaths were reported to the Representative were not in care (90 per cent), but otherwise receiving reviewable services, such as services and supports for Children and Youth with Special Needs (CYSN). Known living arrangements for First Nations children and youth who died included family homes (67 per cent), hospitals (13 per cent), independent living arrangements (five per cent), foster homes (three per cent), homelessness (two per cent) or staffed residential resources (one per cent). This was similar for deaths reported for non-Indigenous children and youth.

Death classification types

Comparison of deaths reported for First Nations and non-Indigenous children and youth revealed some differences (Table 2 provides an overview). Chi-square tests were used to evaluate these differences. The chi-square statistic determines whether significant differences exist between reported numbers of deaths and those that would be anticipated, based on the distribution of the data.⁴⁴

As illustrated in Table 2, most deaths for First Nations children and youth receiving services were classified as “expected” due to natural causes ($n = 33$) or the cause of death was “undetermined” ($n = 25$) by the BC Coroners service.⁴⁵ Undetermined deaths were reported significantly more than anticipated for First Nations children and youth whereas these deaths were reported significantly less than anticipated for non-Indigenous children and youth. Review of individual cases revealed that the majority ($n = 16$) of the undetermined deaths were infants who died in their sleep. This is reflected by findings of a review of childhood mortality in B.C. In the review, the Coroners Service noted that 33 per cent of deaths for those under one year of age were undetermined and occurred during sleep. In this review, 31 per cent of infants who died suddenly and unexpectedly were identified as Indigenous. This percentage is the same as an earlier review (2008 to 2012) and signifies an over-representation of Indigenous infants based on population proportion.⁴⁶ Rather than making new recommendations, the report summarized other recommendations made by the BC Coroners Service, including:

- promote connectedness to peers, family, community and culture
- reduce barriers and increase access to services
- promote cultural safety and humility and trauma-informed care
- elicit feedback through community engagement.

Conversely, the Representative received a significantly smaller proportion of expected death reports for First Nations children and youth than she did for non-Indigenous children and youth. In fact, while 62 per cent of deaths reported for non-Indigenous children and youth were classified by the coroner as expected, only 38 per cent of deaths reported for First Nations children and youth were expected.

⁴⁴ In this case, significant differences mean that there is a five per cent or smaller chance that differences in reported versus expected frequencies could occur by chance.

⁴⁵ See Appendix D for definitions. All death classifications follow the coroner’s classifications.

⁴⁶ BC Coroners Service, Child Death Review Unit, *Child Mortality in British Columbia, 2016* (Victoria, B.C.: Ministry of Public Safety and Solicitor General), 2018.

It is important to remember that expected deaths are only reported where the child or family are receiving reviewable services. Often children and youth with expected deaths are receiving services through CYSN. It is possible that fewer expected deaths are reported for First Nations children and youth because there are greater barriers to accessing CYSN services and supports for First Nations – but not non-Indigenous – children, youth and families. The Representative has learned, through community consultations and investigations, that First Nations families are hesitant to apply for or access CYSN programs and services as these are closely tied to the child welfare system. Further, there is a lack of services available in many First Nations communities and services that are available are rooted in Western models of care and are not culturally attuned.⁴⁷ It could also be the case that First Nations families of children with medical complications that lead to expected deaths are supported in other ways (e.g., through their Nation or through informal supports). Further exploration of supports accessed and any barriers to support may provide important information for planning services and supports for First Nations children and youth with special needs and their families.

A review of First Nations deaths conducted by the BC Coroner's Service and the First Nations Health Authority (FNHA) found that unexpected deaths were more common for First Nations youth and young adults, than for their non-Indigenous peers.⁴⁸ In this review, unexpected deaths were those due to unintentional injury, overdose, suicide or homicide. The review examined the circumstances of 95 deaths of First Nations youth and young adults aged 15 to 24 years between 2010 and 2015. Results revealed that First Nations and non-Indigenous youth and young adults died for similar reasons, but First Nations young people died at a rate almost two times that of their non-Indigenous peers. The review emphasized the need for prevention approaches that *“consider the unique cultural diversity, community strengths and protective factors, as well as factors that wear away at resilience.”* The review also noted that many of the young people had contact with support services prior to death but experienced barriers to accessing and utilizing the supports. Missed opportunities for support of First Nations youth, particularly those with experiences of personal and/or intergenerational trauma, mental health concerns and substance use issues, can have devastating consequences. While the Representative did not examine previous mental health concerns or substance use issues for the First Nations children and youth with reported deaths, analysis of the electronic record for First Nations youth with injuries revealed significant concerns. Further, not all those children and youth with mental health and/or substance use concerns were connected to formal supports.

Between 2015 and 2017, the Representative received 137 reports of unexpected deaths. Accidental deaths were reported primarily for youth aged 12 to 18 years and were often attributed to transport accidents or suspected overdose. This was similar for deaths reported for non-Indigenous children and youth.⁴⁹

⁴⁷ B.C. Representative for Children and Youth, *Alone and Afraid: Lessons learned from the ordeal of a child with special needs and his family* (Victoria, B.C.: Representative for Children and Youth), 2018.

⁴⁸ BC Coroners Service and First Nations Health Authority, *A Review of First Nation Youth and Young Adult Injury Deaths: 2010-2015* (Victoria, B.C.: Ministry of Public Safety and Solicitor General and First Nations Health Authority), 2017.

⁴⁹ The proportion of death by suspected overdose was slightly higher for non-Indigenous children and youth than First Nations, children and youth.

Results

There was a larger proportion of suicide deaths reported to the Representative for First Nations youth (14 per cent) than non-Indigenous youth (eight per cent), although the difference was not statistically significant. The BC Coroners Service also noted a disproportionately high number of suicide deaths for Indigenous youth. Between 2013 and 2018, 23 per cent of suicide deaths in B.C. were reported for First Nations youth.⁵⁰ This report urged child- and youth-serving systems to adopt trauma-informed practices that recognize and acknowledge the impact of ongoing and historical trauma. Further, the Coroner's Service advocated for government bodies to engage with Indigenous communities when creating policies and programs, as well as reviewing existing services to ensure they are delivered in culturally intelligent ways. Finally, the report advised government bodies to support Indigenous communities' right to self-determination.

There seems to be a strong relationship between connection to culture and suicide for First Nations youth. A review of First Nations youth who died by suicide between 1992 and 2006 also found a high rate of suicide but determined that this was not evenly distributed across the province. In fact, 60 per cent of B.C. First Nations reported no suicide for youth aged 15 to 24 years during this time. Results revealed that First Nations youth from communities that had worked to restore cultural practices disrupted by colonization were less likely to die by suicide.⁵¹

Table 2. Types of deaths reported for First Nations and non-Indigenous children and youth

| Death classification | First Nations n (%) | Non-Indigenous n (%) |
|----------------------|------------------------|-------------------------|
| Expected | 33 (38%) | 133 (62%) |
| Undetermined | 25 (29%) | 18 (8%) |
| Accidental | 14 (16%) | 40 (19%) |
| Suicide | 12 (14%) | 18 (8%) |
| Homicide | 3 (3%) | 7 (3%) |
| Total | 87 | 216 |

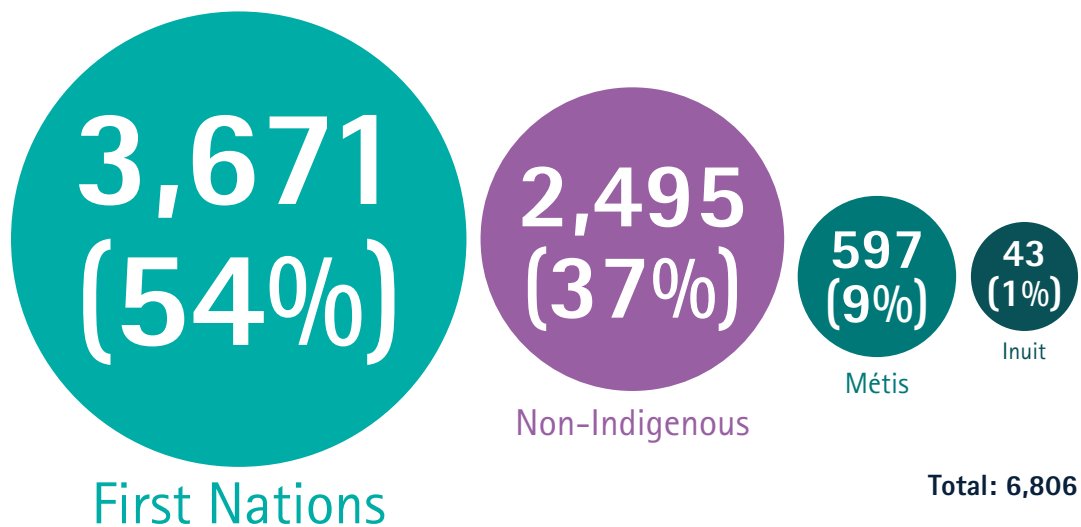
⁵⁰ BC Coroners Service, *Supporting Youth and Health Professionals: A Report on Youth Suicides, January 1, 2013 to June 30, 2018* (Victoria, B.C.: Ministry of Public Safety and Solicitor General), 2019.

⁵¹ Michael J. Chandler and Christopher Lalonde, "Cultural continuity as a hedge against suicide in Canada's First Nations," *Transcultural Psychiatry* 35, no. 2 (1998): 1-20, <https://doi.org/10.1177/136346159803500202>.

Overview of Injury Data

MCFD has reported that there were 3,671 First Nations children and youth in government care on Dec. 31, 2017.⁵² Figure 2 provides an overview of children and youth in care by Indigeneity.

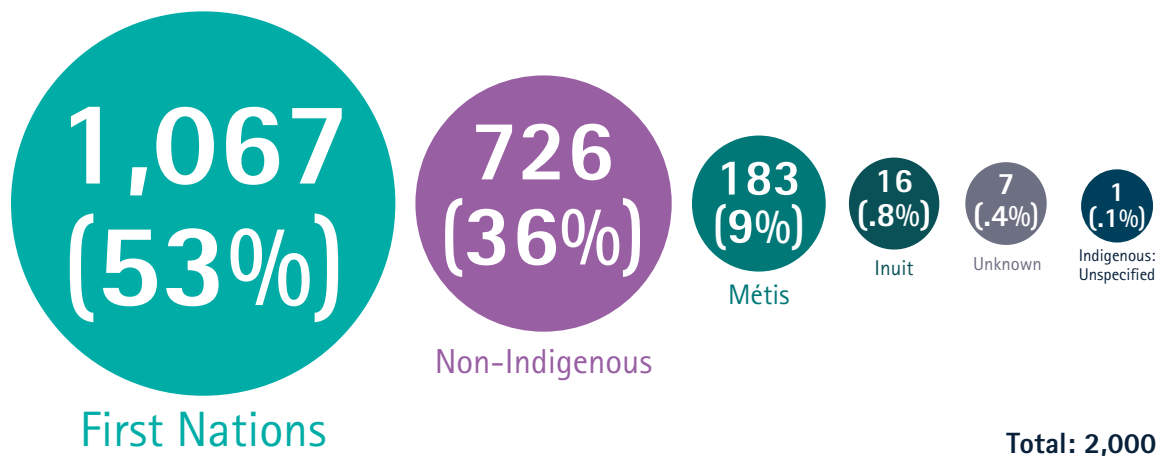
Figure 2. Children and youth in care by Indigeneity



Note: percentages may not total to 100 due to rounding

These numbers were similarly reflected in the proportions of injuries reported to the Representative. In contrast to reported deaths, Figure 3 shows that more injuries were reported for First Nations children and youth than were reported for non-Indigenous children and youth. Between Jan. 1, 2015 and Dec. 31, 2017, 1,067 injuries were reported to the Representative for First Nations children and youth. This accounted for 53 per cent of all in-mandate critical injury reports received in this three-year time period. Seven hundred and twenty-six injuries (36 per cent of the total) were reported for non-Indigenous children and youth.

Figure 3. Injuries reported by Indigeneity



⁵² MCFD Corporate Data Warehouse, retrieved July 23, 2018.

Results

In the following section of the report, injuries are described by the gender and age of the children and youth who experienced them. As with deaths, the chi-square statistic was used to evaluate differences between reported injuries and the number of injuries expected. This demographic information is provided to describe the cohort of young people experiencing injuries. It is the Representative's hope that this provides baseline information that informs planning for future services and supports. Next, systems issues related to injuries are explored. Analyses centre on ways in which systems contribute to injury or protect from harm. Injuries reported for non-Indigenous children and youth are provided for comparison.

Age and gender

Most injuries (all injury types) were reported for female children and youth (65 per cent). However, this was more pronounced for First Nations children and youth; more than half (61 per cent) of injuries reported for females were reported for First Nations children and youth. This was significantly higher than expected, given the distribution of the data. Four injuries were reported for First Nations children and youth identified as gender diverse and this was significantly less than expected.

Table 3. Expected and reported injuries

| | | Female | Male | Gender Diverse |
|----------------|----------------|--------|------|----------------|
| First Nations | Expected count | 696 | 362 | 9 |
| | Reported count | 718+ | 345 | 4- |
| Non-Indigenous | Expected count | 474 | 246 | 6 |
| | Reported count | 452 | 263+ | 11+ |

+ Indicates that the reported count is significantly higher than the expected count

- Indicates that the reported count is significantly lower than the expected count

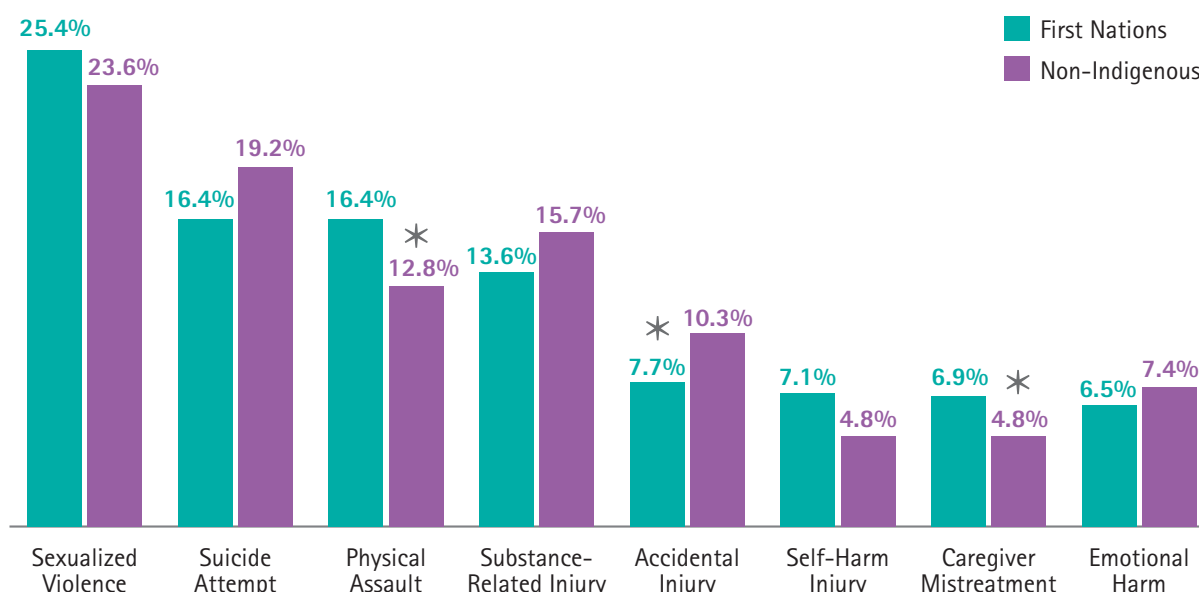
Injuries were more commonly reported for youth aged 13 years and older for both First Nations and non-Indigenous children and youth. There was a significant difference in age at time of injury for First Nations children and youth ($M = 13.7$ years), as compared to non-Indigenous children and youth ($M = 14.4$ years). In other words, injuries were reported more commonly for younger First Nations children and youth, as compared to injuries reported for non-Indigenous children and youth.

Types of injuries reported

Overall, there were significantly more injuries reported for First Nations children and youth than non-Indigenous children and youth. Injuries were coded into eight categories and Figure 4 describes the number of injuries reported by type and Indigeneity.⁵³

⁵³ See Appendices B and D for methods and definitions.

Figure 4. Number of injuries by type and Indigeneity



Significant differences between comparisons are denoted in graphs with an asterisk (*).

The most commonly reported injury for First Nations and non-Indigenous children and youth was sexualized violence. Sexualized violence was reported significantly more than expected for female children and youth and less than expected for male children and youth. The highest proportion of sexualized violence injuries were reported for youth aged 13 to 18 years old.

Suicide attempts were also commonly reported. As with sexualized violence, suicide attempts were more commonly reported for female than male children and youth. Suicide attempts were also reported significantly more than expected for youth aged 13 to 18 years old and less than expected for children aged 12 years and younger.

Physical assault injuries were reported significantly more than expected for First Nations youth and less than expected for non-Indigenous children and youth. Further, these injuries were reported significantly more than expected for male youth and less than expected for female youth. The highest proportion of physical assault injuries were reported for youth aged 13 to 18 years old.

Substance-related injuries accounted for 14 per cent of injuries reported for First Nations children and youth and 16 per cent of injuries reported for non-Indigenous children and youth. The difference in the proportion of substance-related injuries by Indigeneity was not significant. Substance-related injuries were reported relatively equally for male (14 per cent) and female (15 per cent) children and youth. Not surprisingly, substance-related injuries were reported predominantly for youth aged 13 to 18 years.

Unlike other injury types, there were more accidental injuries reported for non-Indigenous children and youth (10 per cent) than First Nations children and youth (eight per cent). Accidental injuries were reported significantly more than expected for non-Indigenous children and youth, given the distribution of the data.

Results

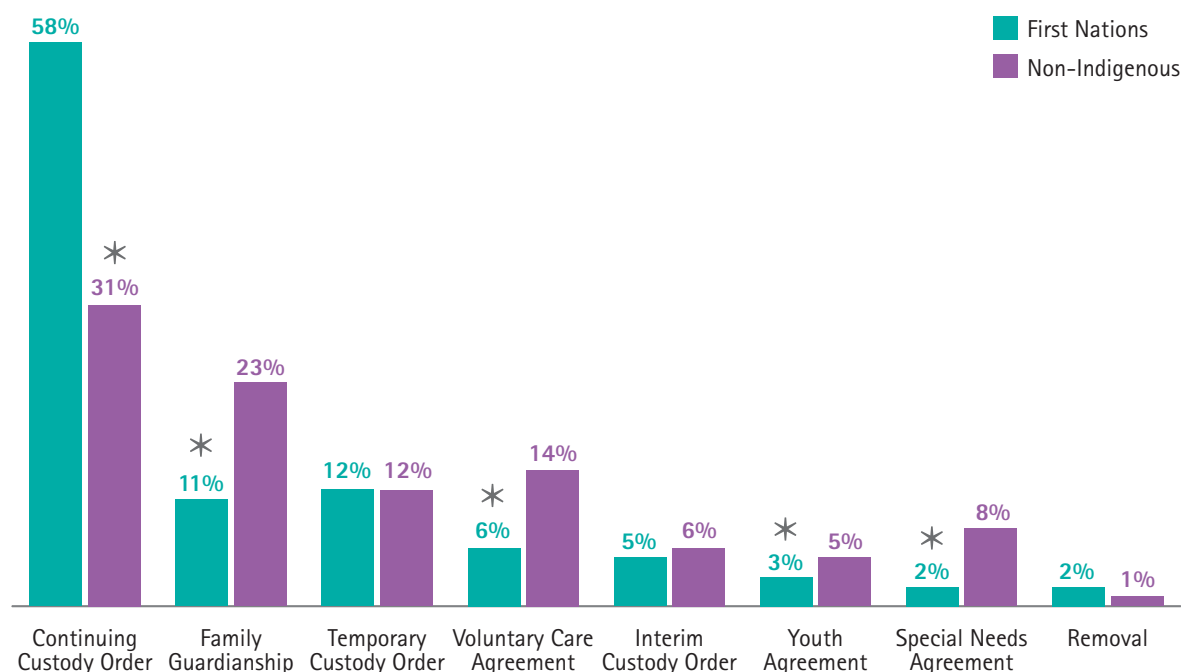
Caregiver mistreatment injuries were reported significantly more than expected for First Nations children and less than expected for non-Indigenous children.⁵⁴ Similar to physical assault injuries, caregiver mistreatment injuries were reported significantly more than expected for male children and significantly less than expected for female children. The highest proportion of caregiver mistreatment injuries were reported for children aged 12 years and younger. More than half of caregiver mistreatment occurred in foster homes (59 per cent) and just over one-fifth (22 per cent) occurred in staffed resources. Only 19 caregiver mistreatment injuries (14 per cent) were reported for those in the care of their family and only three injuries (two per cent) were reported for those in a restricted foster home.⁵⁵

Emotional harm injuries made up the smallest proportion of injuries and were reported equivalently for First Nations and non-Indigenous children and youth. Emotional harm was reported significantly more than expected for male children and youth and for children and youth aged 12 and younger.

Systems characteristics associated with injuries

Legal status. The number and type of injuries reported was found to vary with a child or youth's legal status (see Figure 5).

Figure 5. Percentage of injuries by legal status



Significant differences between comparisons are denoted in graphs with an asterisk (*).

See Appendix D for definitions of legal statuses.

⁵⁴ This injury category is inclusive of children in- and out-of-care. For those in care of MCFD, the *CFCS Act* defines a caregiver as a person with whom a child is placed by a director and who, by agreement with the director, is authorized to carry out the rights and responsibilities of the director.

⁵⁵ Restricted foster homes are those in which a child in care is placed with caregivers who have a prior relationship with the child (e.g., extended family, family friends). The foster home is approved for that child only and approval terminates when the child leaves the home.

The highest proportion of injuries was reported for First Nations children and youth who were in care via Continuing Custody Order (CCO) at the time of injury.⁵⁶ More than half of injuries (57 per cent) reported for First Nations children and youth were reported for those who were CCO. This was significantly more than expected, given the distribution of the data. In comparison, 30 per cent of injuries reported for non-Indigenous children and youth were for those who were CCO. This was significantly less than expected, given the distribution of the data.

There were also significant differences in number of injuries by legal status for children and youth in the guardianship of family, in care via Voluntary Care Agreement (VCA) and Special Needs Agreement (SNA), and for those supported through a Youth Agreement (YAG). In these cases, more injuries were reported for non-Indigenous than First Nations children and youth.⁵⁷

The above pattern was consistent across injury types. For example, sexualized violence injuries reported for those who were CCO were most commonly reported for First Nations children and youth. However, for children and youth in care via VCA and SNA, a higher proportion of sexualized violence injuries were reported for non-Indigenous children and youth than First Nations children and youth (see Figure 6).⁵⁸ Future research could examine the factors that contribute to these differing patterns of injury.

First Nations Children and Youth Not in Care

There were 155 injuries reported for First Nations children and youth receiving reviewable services but who were not in care of MCFD or a DAA. This represents 15 per cent of all the injuries reported for First Nations children and youth. These children and youth were in the guardianship of family (their parents or another family member), supported by a Youth Agreement (YAG), or were living on their own. (See Appendix D for definitions.)

Physical assaults were most commonly reported, particularly for males. Suicide attempts were the second most commonly reported injuries, followed by sexualized violence. As with those in care, sexualized violence was predominantly reported for females.

A common theme throughout RCY consultations with First Nations leaders, community members and service providers was curiosity about supports for those not in care. Keeping children and youth with family was a priority for many and a need for more support services and regular contact with supports was identified. Often, consultations identified poverty as a pressing concern for families. While there are likely myriad reasons that so few injuries were reported for children and youth not in care, the Representative is concerned about this cohort.

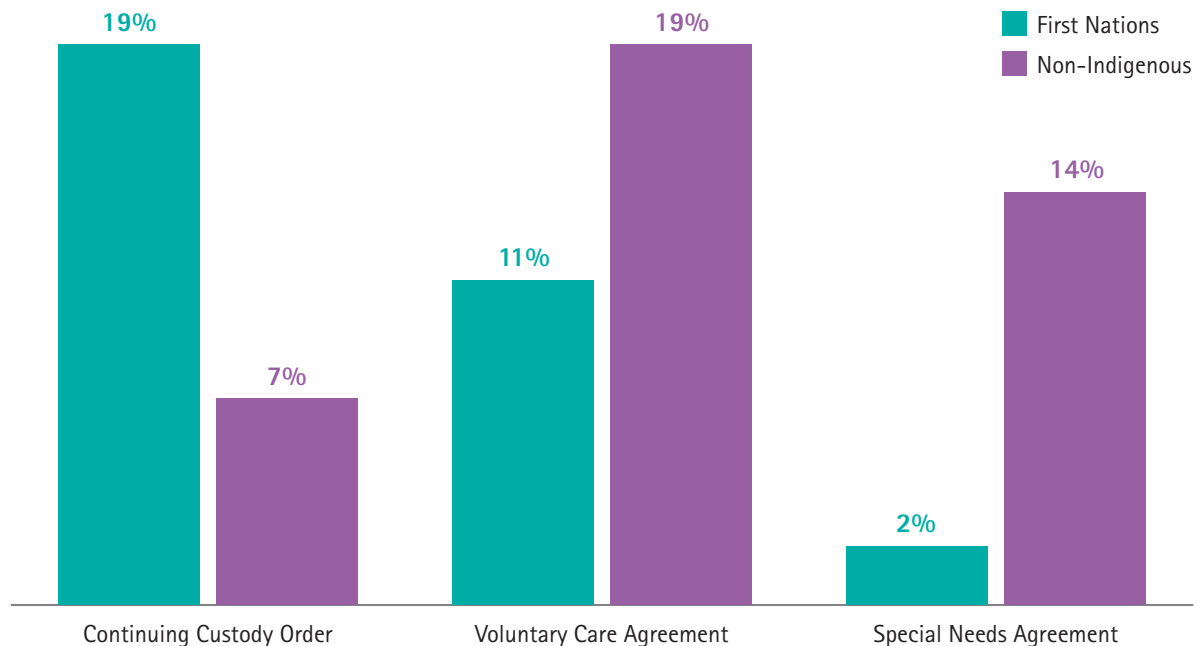
⁵⁶ See Appendix D for definitions of different legal statuses.

⁵⁷ Children and youth in care via VCA and SNA remain under the legal guardianship of their parents.

⁵⁸ See Appendix C for a more in-depth description of injury types by legal status.

Results

Figure 6. Percentage of sexualized violence injuries by in-care legal status



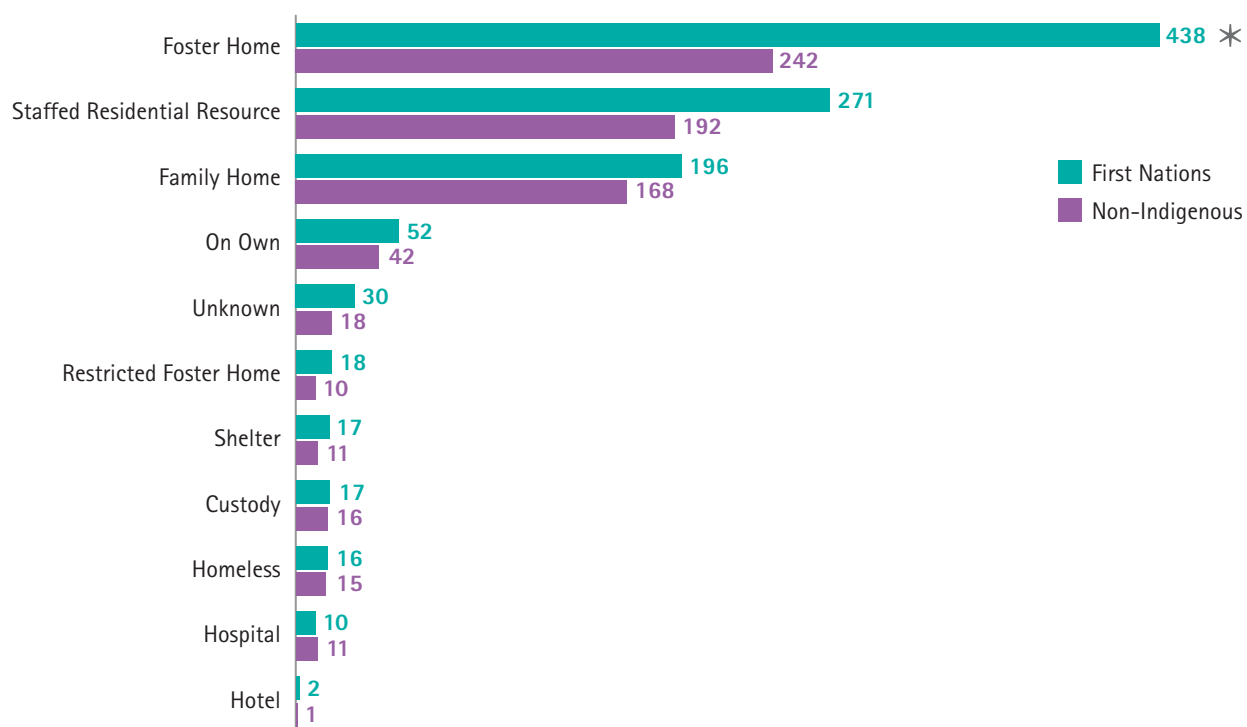
Living arrangement: Injuries were reported significantly more than expected for First Nations children and youth living in foster homes but significantly less than expected for non-Indigenous children and youth living in foster homes (see Figure 7). Sexualized violence injuries were most commonly reported for those living in foster homes, followed by suicide attempts.

Alternately, injuries were reported significantly more than expected for non-Indigenous children and youth living in their family's home. Suicide attempts were most commonly reported for those living in a family home, followed by sexual assault and then emotional harm.

There was no significant difference between the expected and reported numbers of injuries by Indigeneity for the other living arrangements. One-quarter of injuries were reported for those living in a staffed residential resource (SRR). This is interesting as only 12 per cent of children and youth in care were placed in a SRR at the end of December 2017.⁵⁹ The majority of injuries for those placed in staffed resources were sexualized violence (25 per cent) and substance-related injuries (21 per cent).

⁵⁹ MCFD Corporate Data Warehouse, retrieved August 17, 2020.

Figure 7. Number of injuries by living arrangement



Significant differences between comparisons are denoted in graphs with an asterisk (*).

Urban and rural locations

The term ‘urban’ is hard to define and even when defined is often contested. Broadly, urban can refer to populations of a certain size, the population density of an area, or by criteria of functionality (such as accessibility to services like hospitals, libraries, medical specialists, transportation infrastructure, shopping, technology, etc.). Statistics Canada describes urban as a minimum population (1000 people) and a minimum population density (400 people/km²) and then classifies this into small, medium and large population centres.⁶⁰ For the purposes of this data set, access to services for children, youth and their families was considered an important indicator of the size of a population centre. Therefore, the current analyses use the following definitions:

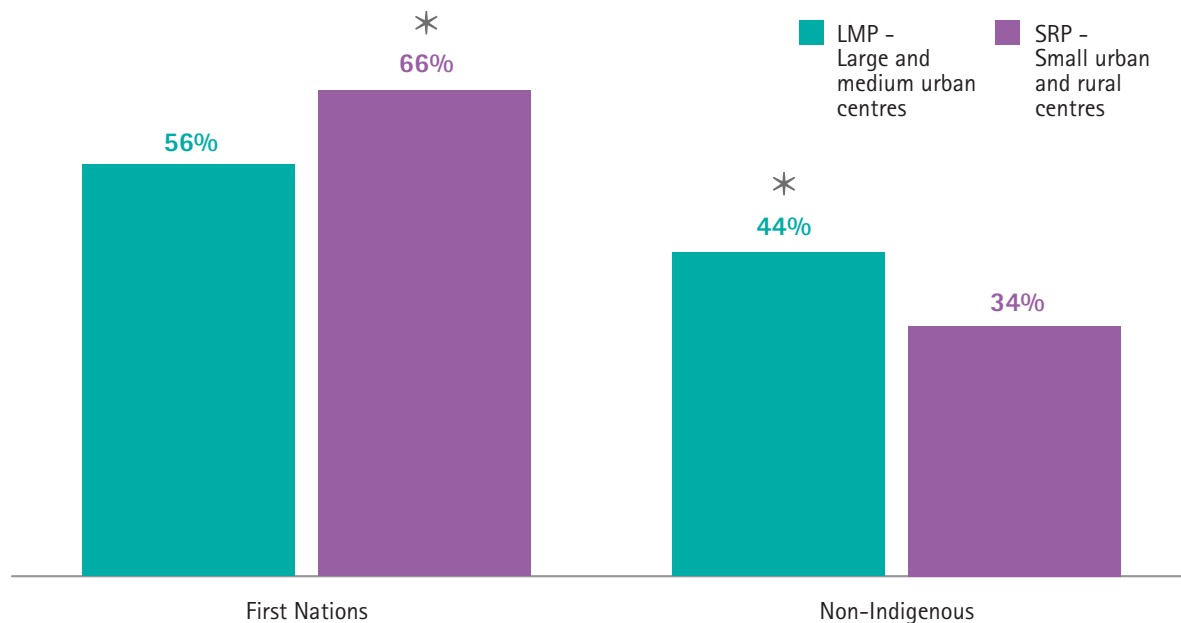
- large and medium urban centres (LMP) = population of 30,000 and more
- small urban and rural centres (SRP) = population of less than 30,000.

As expected, there were more injuries reported for those living in LMP ($n = 1,191$) than SRP ($n = 602$). Interestingly, analyses revealed that more injuries were reported than expected for First Nations children and youth living in SRP. On the other hand, injuries were reported significantly more than expected for non-Indigenous children and youth living in LMP.

⁶⁰ Statistics Canada, “Population Centre and Rural Area Classification 2016,” Statistics Canada, last modified Feb. 8, 2017, <https://www.statcan.gc.ca/eng/subjects/standard/pcrac/2016/introduction>.

Results

Figure 8. Percentage of injuries by population centre



Significant differences between comparisons are denoted in graphs with an asterisk (*).

Sexualized violence was reported most commonly for both population centres but other injury types were reported differently by location. Suicide attempts were reported significantly more than expected in SRP and significantly less than expected in LMP. Similarly, caregiver mistreatment was reported significantly more than expected in SRP and significantly less than expected in LMP. Accidental injuries were also reported significantly more than expected in SRP and significantly less than expected in LMP.

Alternately, substance-related injuries were reported significantly less than expected in SRP but significantly more than expected in LMP. Emotional harm was also reported significantly less than expected in SRP but was reported as expected in LMP.

There was a different pattern of injuries reported for First Nations and non-Indigenous children and youth in LMP but not SRP. Physical assaults were reported significantly more than expected for First Nations youth in LMP but significantly less than expected for non-Indigenous children and youth in LMP. Accidental injuries were not commonly reported for those in LMP but were reported significantly less than expected for First Nations children and youth in LMP but significantly more than expected for non-Indigenous children and youth in LMP.

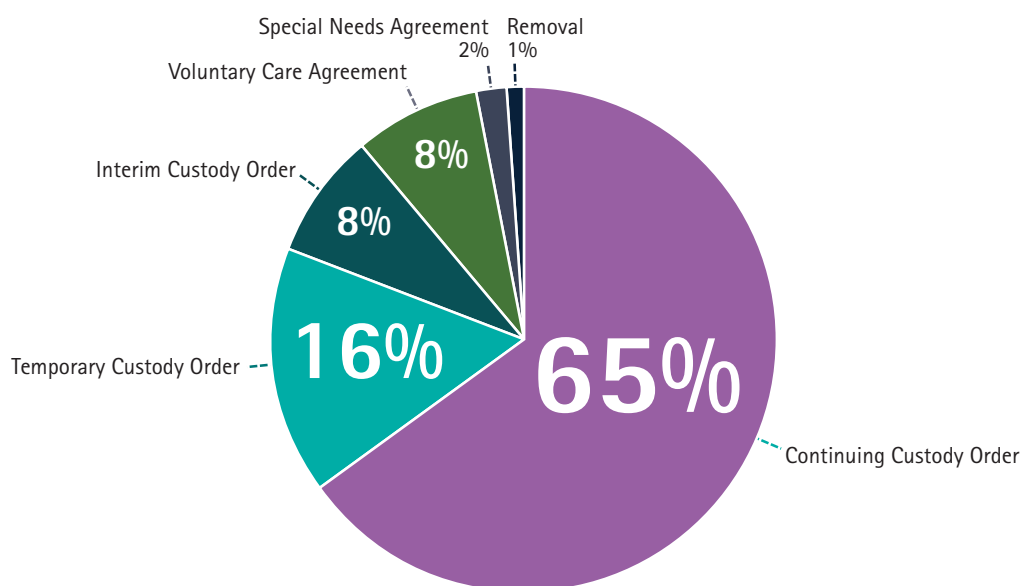
Analysis of Electronic Records

Care Plans on file at the time of injury were examined for a stratified random sample to provide more information about First Nations children and youth in care with reported injuries. In consultations, leadership, service providers and community members were curious about:

- mental health needs and the provision of mental health services, particularly Aboriginal Child and Youth Mental Health (ACYMH) and any traditional healing practices offered⁶¹
- neurodevelopmental concerns
- injuries in rural and remote locations, as well as the context for Urban Indigenous youth
- injuries for those youth close to adulthood and what supports are needed.

Children and youth without a Care Plan in their electronic record were excluded from the stratified sample. Of those with Care Plans, two-thirds ($n = 134$) of children and youth had current Care Plans at the time of injury, approximately one-third ($n = 63$) had Care Plans that were more than a year old, and three children and youth in the sample had interim Care Plans.⁶² Note that if there was no Care Plan in the electronic record, the record was removed from the sample and replaced with another child or youth who did have a Care Plan and fit the criteria.⁶³ The majority of children and youth were in care via CCO (see Figure 9 for care status at the time the Care Plan was written).

Figure 9. Care status of First Nations children and youth at time of Care Plan creation



See Appendix D for definitions of legal statuses.

⁶¹ ACYMH incorporates ‘mainstream’ and ‘Aboriginal’ healing interventions to support children, youth and their families.

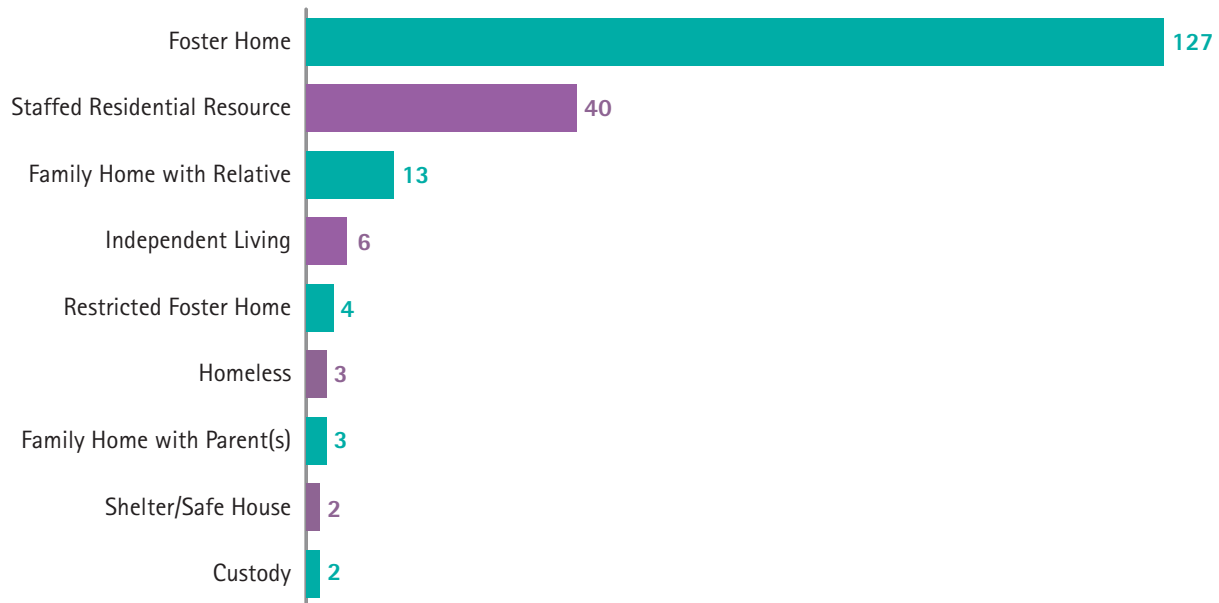
⁶² Policy directs that a child in care must have an interim Care Plan created within 30 days of coming into care and a full Care Plan written within six months of coming into care. The Care Plan must be reviewed, at minimum, every six months. Care Plan reviews should involve the child or youth’s care team and an Indigenous child or youth’s community. Practitioners are directed to make reasonable efforts, at least annually, to involve an Indigenous child or youth’s Indigenous community in planning for a child or youth who is under a continuing custody order. A new Care Plan must be created for each child or youth in care annually.

⁶³ There were 30 children and youth in care who were missing Care Plans (15 per cent).

Results

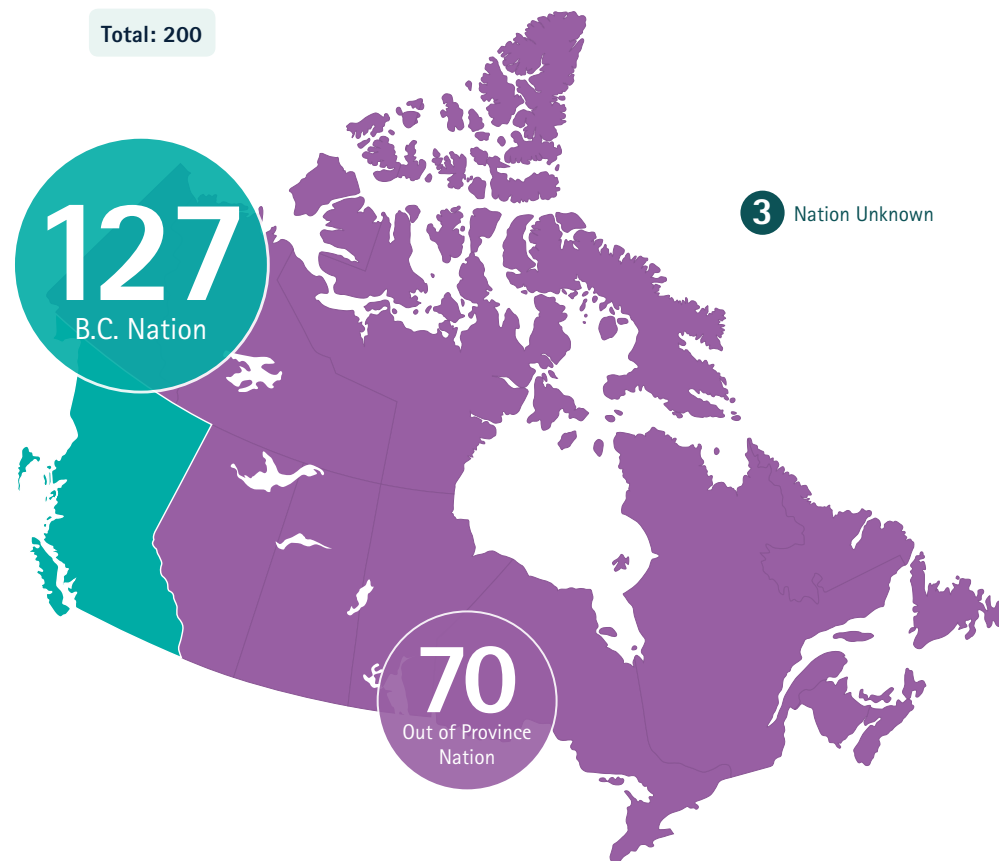
The average age that these children and youth entered care was seven years. Children and youth belonged to Nations from all over B.C., but, interestingly 35 per cent ($n = 70$) belonged to Nations from outside B.C. (see Figure 11). Three children and youth were known to be First Nations, but their specific Nation affiliation was unknown. The majority of children and youth lived in foster homes (see Figure 10).

Figure 10. Living arrangement for First Nations children and youth in care



There was no evidence that the child or youth's Nation was involved or informed in care planning in almost half of cases (46 per cent). Children and youth belonging to Nations from outside B.C. were less likely to have their Nation informed or involved in care planning.⁶⁴

Figure 11. Involvement of Nations as indicated by Care Plan review



⁶⁴ MCFD policy, effective June 30, 2017, directed practitioners to make reasonable efforts to include Indigenous communities in care planning at least annually. The policy was revised again in 2019 to require those efforts to include multiple attempts to connect with a child's Indigenous community. Since amendments to the *CFCS Act*, an Indigenous community that has an agreement with the Director under section 92.1 conducts planning and decision-making in accordance with that agreement. Effective Jan. 1, 2020 (therefore not during the data presented herein), policy explicitly notes two purposes:

1. To provide guidance respecting the identity of Indigenous children and collaboration with Indigenous communities; and
2. To outline how *An Act respecting First Nations, Inuit and Métis children, youth and families (Federal Act)* modifies a director's powers and duties under the *Child, Family and Community Service Act (CFCS Act)*.

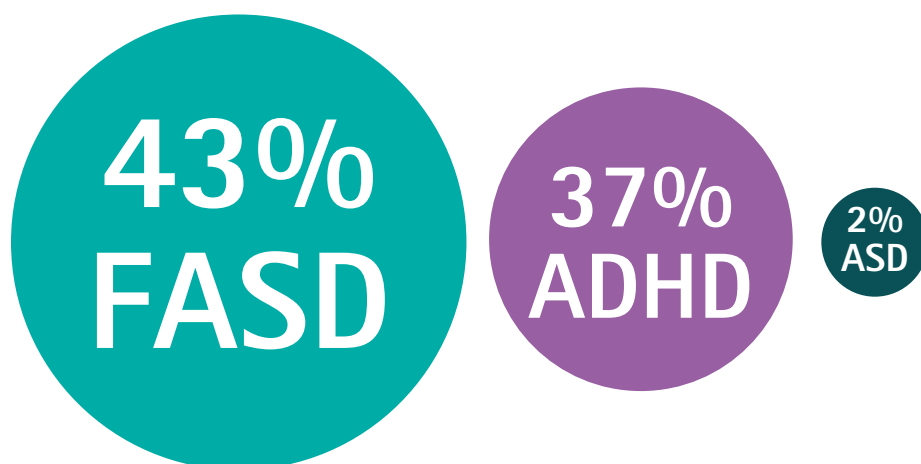
Additionally, where a conflict or inconsistency between national standards under the *Federal Act* and the *CFCS Act* in relation to Indigenous children may exist, the national standards must prevail, thus altering the Director's commitments and the court's considerations in relation to Indigenous children. MCFD provides a hyperlink for service providers as a reference in these matters: <https://www2.gov.bc.ca/gov/content/governments/indigenous-people/supporting-communities/child-family-development/repository-of-agreements>.

Cultural continuity and promoting a child's attachment and emotional ties to family when separated are now explicitly defined and involvement with Indigenous community is specifically prescribed.

Developmental and mental health concerns

Analysis of Care Plans provides a snapshot of developmental and mental health concerns.⁶⁵ As shown in Figure 12, a considerable portion of children and youth in the sample were labelled as having FASD (43 per cent) and ADHD (37 per cent), while only two per cent of the sample had a diagnosis of Autism Spectrum Disorder. This observation is echoed in the Representative's exploration of services and supports for children and youth with FASD and their families. This report, to be released in the coming months, highlights the tendency to assume FASD for First Nations children and youth with developmental or behavioural concerns, rather than conducting fulsome assessments.

Figure 12. Developmental concerns highlighted in Care Plans for First Nations children and youth in care



Mental health concerns were also identified through a review of Care Plans.⁶⁶ It is important to note that the Care Plans and electronic records are populated by practitioners and can include both professional (psychiatrist, psychologist or other medical experts) diagnoses and anecdotal information about the child or youth's developmental and mental health concerns. Figure 13 highlights relatively high rates of anxiety or panic attacks (29 per cent), depression (25 per cent) and post-traumatic stress disorder (13 per cent).⁶⁷ Analyses also indicate lower rates of psychosis (three per cent), eating disorders (three per cent), personality disorders (two per cent) and bipolar disorder (one per cent). Not surprisingly then, 30 per cent of these youth were receiving mental health supports through Child and Youth Mental Health (CYMH) and 60 per cent were identified as receiving other mental health services (Table 4 provides details on the reviewable services accessed by the youth in the sample). Some of these youth were

⁶⁵ Although Care Plans were not explored for non-Indigenous children and youth, Appendix D includes definitions and rates of these developmental and mental health concerns in the general population.

⁶⁶ Note that Care Plans are not reviewed by mental health professionals, such as psychiatrists or psychologists. Mental health concerns are noted and may stem from formal assessment results but may also reflect symptoms and/or behaviours displayed by children and youth.

⁶⁷ A recent report commissioned by the Representative from Simon Fraser University's Child Health Policy Centre assessed the anticipated impact of COVID-19 on child and youth mental health. The authors noted that we can anticipate a significant increase in childhood anxiety, depression, PTSD and behavioural challenges as a result of the stressors associated with the pandemic. See Representative for Children and Youth, *COVID-19 and the Impact on Children's Mental Health* (Victoria, B.C.: Representative for Children and Youth), 2020, <https://rcybc.ca/reports-and-publications/covid-19-and-the-impact-on-childrens-mental-health/>.

receiving both CYMH and other mental health services. Only four per cent of these youth were noted to be receiving supports through Aboriginal Child and Youth Mental Health (ACYMH).

Aboriginal Child and Youth Mental Health

MCFD delivers or funds Aboriginal Child and Youth Mental Health (ACYMH) services in B.C. ACYMH includes core CYMH services (i.e., triage, resource and support services, mental health assessment, treatment planning, therapeutic intervention and consultation) as well as approaches designed to respond specifically to Indigenous communities. These approaches can include:

- relationship-building with communities
- outreach services
- mental health therapy provided in a variety of settings, including homes, schools and on the land
- family-centered and community-centred services
- holistic view of mental wellness
- understanding of historical and intergenerational traumas affecting the mental health of Indigenous children and youth.

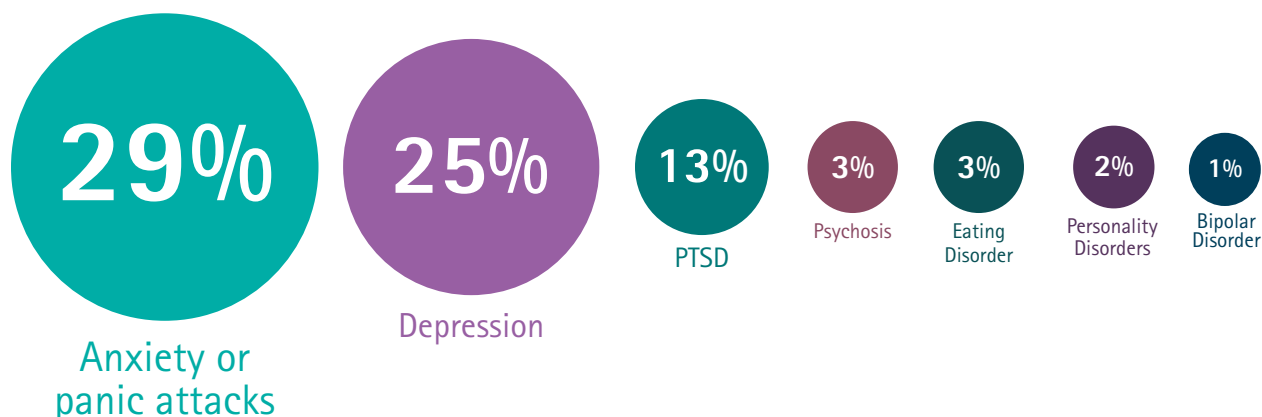
Only four per cent of those Care Plans reviewed for the current report revealed ACYMH involvement. The Representative learned from MCFD that there are only six ACYMH teams in six B.C. communities. Given the small number of ACYMH teams, the number of referrals that can be accepted by the service is limited. MCFD informed the Representative that ACYMH services are often provided by DAAs. However, DAAs reported that they do not have regular funding to provide ACYMH; rather, they are required to apply for grants or fundraise to support ACYMH.

CYMH and ACYMH are only available to those with diagnosed mental health disorders, so supports are not available to all children or youth who may need support such as those experiencing distress due to trauma. In addition, more complex mental health disorders, such as psychosis, eating disorders, personality disorders and bipolar disorder require specialist services that are not provided by CYMH or ACYMH. Supports for those with these disorders may be provided by health authorities but those services may not be culturally attuned or culturally safe.

Further, consultation with First Nations leaders, service providers, and community members revealed concerns with ACYMH. It was reported that ACYMH does not provide Indigenous-specific approaches, as it is intended to do. DAA staff expressed concern that, rather than being rooted in Indigenous views of healing and wellness, ACYMH services are no different than those offered by mainstream CYMH. Consultations noted the need for mental health services for First Nations children and youth to be informed by communities as community members know best how to support mental wellness for their children and youth.

Results

Figure 13: Mental health concerns highlighted in Care Plans for First Nations children and youth in care



It is important to note that more than half of the children in the cohort had evidence of complex trauma (59 per cent).⁶⁸ One quarter of children and youth in the sample had identified substance use issues (25 per cent) but only 13 per cent of the sample were noted to be receiving addictions services. Table 4 provides an overview of reviewable services noted by Care Plans to be involved with First Nations children and youth in the sample.

Table 4. Percentage of First Nations children and youth involved in different reviewable service areas⁶⁹

| Reviewable Service Area | Per Cent of Sample |
|--|--------------------|
| Child and Family Services ⁷⁰ | 100 |
| Other Mental Health Services | 60 |
| Child and Youth Mental Health | 30 |
| Youth Justice | 14 |
| Addiction Services | 13 |
| Children and Youth with Special Needs | 7 |
| Aboriginal Child and Youth Mental Health ⁷¹ | 4 |

Only five per cent of children and youth had documented access to traditional healing or Indigenous mental health practices.

Stability in placement was explored for this sample of children and youth. Results revealed that these children and youth experienced, on average, seven different placements by the time they experienced an injury. Nearly three quarters (72 per cent) of children and youth experienced multiple placements (i.e., three or more). Children and youth aged 13 to 18 experienced higher numbers of placements

⁶⁸ Complex trauma includes both the young person's exposure to multiple traumatic events and the long-term effects of these exposures. These events can include profound neglect, abuse and violence.

⁶⁹ Note that children and youth may have been involved in multiple reviewable service areas.

⁷⁰ Note that in order to be included in the sample, children and youth had to have had involvement with Child and Family Services.

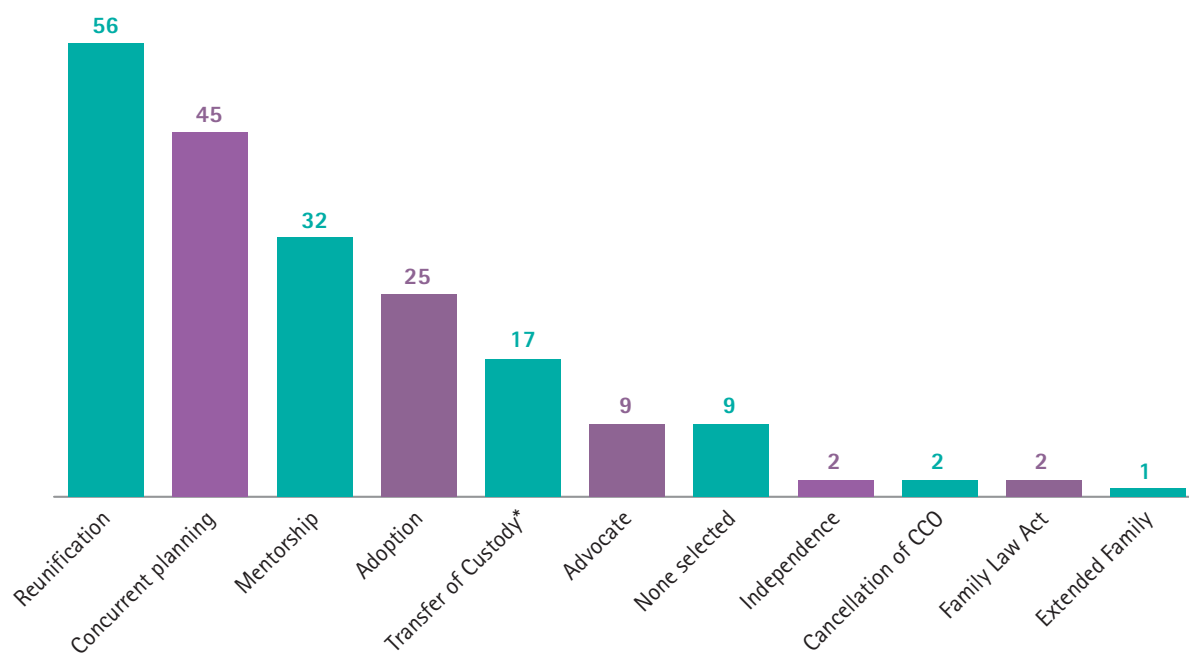
⁷¹ Aboriginal CYMH would also be counted within CYMH in this table.

than children 12 years and younger. The average number of placements for female adolescent youth in this group was 8.45 while in care and the average for males of similar ages was 6.97 placements while in care.

Permanency goals were explored for this sample of youth with reported critical injuries (see Figure 14 for details). The majority of plans indicated that children and youth were to be reunited with their families. For more than one-third of First Nations children and youth, concurrent planning was evident; that is, even though the ultimate goal for children and youth was reunification with their families, practitioners were also planning for their care in case reunification was not possible.

Strength: School Attendance
 Most school-aged First Nations children and youth in the sample had been attending school at the time that their Care Plans were written ($n = 151$; 76 per cent).

Figure 14. Permanency goals as identified in Care Plans



* Transfer of custody is often called a “54.1”. This is a permanent transfer of custody as outlined in Section 54.1 of the *CFCs Act*.

Discussion

Analysis here includes injuries and deaths reported to the Representative for First Nations children and youth receiving reviewable services. The Representative prepared these analyses in consultation with First Nations leadership, community members and service providers. This data provides valuable insights into the well-being of First Nations children and youth receiving services and highlights the need for further exploration, guided by those who are supporting children, youth and families. Presented here is a discussion of some key findings from this report, with a focus on those analyses that can inform both current and future service provision as First Nations communities resume jurisdiction over child welfare.

There were 87 deaths and 1,067 injuries reported for First Nations children and youth. Additionally, 200 Care Plans of First Nations youth with reported injuries were explored to examine issues important to First Nations leadership, service providers and community members. The Representative noted the following from the data:

- one-third of deaths reported for First Nations children and youth were accidental, due to suicide, or were homicides
- the majority of injuries reported for First Nations youth were for females
- injuries were most often reported for older youth
- sexual assaults and suicide attempts were most often reported
- physical assault injuries and caregiver mistreatment were reported more often for First Nations children and youth than non-Indigenous children and youth
- injuries reported for First Nations youth were most often reported for those placed in foster homes
- thirty-five per cent of First Nations children and youth included in the stratified random sample were from Nations outside of B.C.
- placement instability was common for those First Nations youth included in the stratified random sample.

Additionally, several themes emerged from quantitative analyses and review of Care Plans.

First Nations Children and Youth in Care

The majority of injuries reported for First Nations children and youth were for those in care of MCFD or a DAA. In particular, legal status had a relationship with the number and types of injuries reported. The highest number of injuries were reported for First Nations children in the permanent care of the Director (CCO).⁷² There was a striking difference in the number of injuries reported for First Nations and non-Indigenous children who were CCO. More than two times the number of injuries were reported for First Nations children and youth who were CCO than non-Indigenous children and youth who were CCO. While there are more First Nations youth under CCO than non-Indigenous youth, results of statistical analyses revealed that, even taking this into account, there was a higher than expected number

⁷² Due to MCFD reporting policy (see Appendix B), the number of injuries reported for children in and out of care cannot be compared. However, it is important to remember that these analyses are descriptive in nature and do not attribute causes to the findings. There are different reasons that the number of injuries reported for those who are CCO is high. For example, it may be that social workers are more involved with children and youth who are CCO and, therefore, are more aware of any injuries.

of injuries reported for First Nations children and youth under CCO. While the reason for this cannot be determined by this report, the Representative is troubled by this statistic.

There was a significant difference between reported and expected injuries for other legal statuses as well, including: family guardianship, VCA, SNA and YAG. In these cases, more injuries were reported for non-Indigenous children and youth than First Nations children and youth. For those in the guardianship of family, in care via VCA or SNA, or supported by YAG, sexualized violence, suicide attempts and physical assaults were reported at equivalent or lower numbers for First Nations children and youth, as compared to non-Indigenous children and youth. Future research should explore injury patterns and experiences of children and youth in out-of-care placements or who are receiving family supports, as has been done here for children and youth in care.

The highest number of injuries was reported for First Nations children and youth living in foster homes. Sexualized violence and suicide attempts were most often reported for First Nations children and youth in foster homes. Further, a high proportion of injuries was reported for children and youth placed in staffed residential resources; sexualized violence and substance-related injuries were reported more frequently for these youth. Results of Care Plan analyses revealed that placement instability was apparent for almost three-quarters of this sample of First Nations children and youth. Stability in placement can foster positive attachment and this may protect against injuries and other negative outcomes for youth. These patterns can inform placement decisions and the ways in which services can support caregivers and youth.

Services for First Nations Children and Youth

The Care Plan analysis indicated that some First Nations children and youth with injuries may not be accessing all the services they need to thrive. Many of the children and youth included in the Care Plan analysis had one or more confirmed mental health concerns. It was heartening to see that many children and youth were accessing mental health supports but four per cent of the sample were noted to be accessing ACYMH. Further, only five per cent of the sample had documented access to traditional healing or Indigenous mental health practices. The First Nations Health Authority (FNHA) promotes land-based healing practices for those with mental health concerns. Some guiding principles of land-based healing include:

- activities that are culturally safe
- connection to local Elders
- cultural and language camps that recognize Indigenous languages are foundational to health
- honouring local strengths and resources: *“building the expertise at home”* – traditional food harvesting projects (e.g., berry picking, fishing, trapping) foster connection to traditional territories and land-based values.⁷³

Context: Traditional Healing

“Kira* has been to her community on several occasions and has partaken in such cultural activities as drum-making, regalia-making, fishing, cooking traditional foods, listening to stories from her Elders and traditional medicine-making. Kira is aware and is very connected to her Aboriginal culture. Kira is a strong Aboriginal youth who is very proud of her culture and has a strong sense of her self-identity and it has been at the forefront of her upbringing.”

– from a youth Care Plan

*Names have been changed.

⁷³ First Nations Health Authority, *What is Land-Based Treatment and Healing?*, First Nations Health Authority, <https://www.fnha.ca/Documents/FNHA-What-is-Land-Based-Treatment-and-Healing.pdf>.

Of note in the Care Plan analysis is the fact that in almost half of the cases (46 per cent) no evidence could be found that the child or youth's Nation was involved or informed that they were in care. While it is beyond the scope of this report to consider why this was the case, it is nonetheless troubling when contemplating the over-involvement of the child welfare system and the lack of involvement of the child or youth's community. There appears to be a pattern in the involvement of the child or youth's Nation when these Nations are located outside of B.C. These young people were less likely to have their Nations involved or informed. The Representative is pleased that the *Federal Act* and MCFD practice now promote cultural continuity and maintaining emotional ties to family when children and youth are separated from them.

Similarly, although FASD and ADHD were prevalent, only seven per cent of the sample were noted to be served by CYSN. One reason for this is likely that, in many cases, unless they also have a co-occurring intellectual disability, Autism Spectrum Disorder or are eligible for the At Home Program, children and youth with FASD and ADHD are not eligible for CYSN services. The Representative has highlighted gaps in services for many children with disabilities, particularly those with invisible disabilities, in previous reports.⁷⁴ School is also an important source of support but 24 per cent of First Nations children and youth in care whose Care Plans were reviewed were not attending school at the time of injury. Seventeen of the youth with FASD were not receiving CYSN supports and were not attending school. Similarly, 16 youth with ADHD were not attending school and only one youth with ADHD had CYSN involvement. Child-serving systems must take these vulnerabilities into account when care planning and designing supports.

Context: Cultural Pride

"Bonnie* clearly identifies as a First Nations person. She is proud of her culture and looks forward to being a part of hands-on cultural activities through school. Bonnie needs to continue to spend time learning about and knowing who she is as a (her First Nation) woman. She has attended community events in (her community) and this should be further encouraged for her to develop a sense of belonging."

– from a youth Care Plan

*Names have been changed.

Injuries in Urban and Rural Contexts

A final theme that emerged from the analyses was the relationship between population centre and the number and type of injuries reported. Some service providers were curious about the experiences of Urban Indigenous youth receiving services whereas others commented on the challenges that come with working in rural and remote locations. In the current data set, a higher than expected proportion of injuries were reported for children and youth living in small or rural population centres. Suicide attempts, caregiver mistreatment and accidental injuries were reported more than expected for children and youth living in these small communities. It may be the case that fewer supports are available in these locations and that this affects the occurrence of injuries. For example, the Representative has noted in past reports that there are fewer available and accessible mental health supports for children and youth in rural or remote communities. Further, caregiver supports, such as respite, may not be readily available.

⁷⁴ B.C. Representative for Children and Youth, *Left Out: Children and youth with special needs in the pandemic* (Victoria, B.C.: Representative for Children and Youth), 2020.

See also *Alone and Afraid: Lessons learned from the ordeal of a child with special needs and his family* (Victoria, B.C.: Representative for Children and Youth), 2018.

In contrast, substance-related injuries and emotional harm were more often reported in large or medium-sized population centres. There are likely multiple reasons why substance-related injuries are reported more frequently in cities, but it may be that dangerous substances are easier to access. Regardless, this finding highlights the importance of available and accessible harm reduction and treatment services for children and youth.⁷⁵

Feedback from Service Providers and Leaders

As this report was taking shape, the Representative directed researchers to reach out to service providers and First Nations leaders to have a conversation about reported critical injuries and deaths. The Representative wanted her analyses of the data to be informed by the interests and requests of First Nations service providers and leadership. Those consultations shaped the analyses that were conducted.

Once analyses were completed and results were synthesized, a draft report was shared in November 2020 with those who were initially consulted as part of an administrative fairness process. Overwhelmingly, service providers and leaders agreed that the results of this report reflected their day-to-day experience serving First Nations children, youth, and families. Service providers and leaders took the opportunity to share further the challenges faced in promoting well-being for First Nations children and youth.

Culturally appropriate mental health services

Our review of 200 care plans for First Nations children and youth in care with reported injuries revealed that few had access to ACYMH or traditional mental wellness services. Service providers echoed this finding and noted that the majority of mental health services and supports are rooted in Western models of therapy. Moreover, service providers report that ACYMH, which is not widely available, often offers the same treatment modalities as mainstream CYMH. They called for ACYMH to be rooted in Indigenous ways of being and knowing. Although First Nations communities know best how to support mental wellness for their children and youth, there is no place for them in designing ACYMH programs and services. In many cases, for DAAs to offer mental health services to children and youth, they are required to piece together different grants or to engage in fundraising activities. This means that programs may not always be available when needed.

Cultural interventions and traditional healing

In addition to ACYMH, initial consultations raised questions about the availability of cultural interventions or traditional approaches to healing. This was reiterated when service providers and leaders reviewed the results of data analysis. They particularly emphasized the need for culturally safe and relevant intervention and prevention services to address sexualized violence. Service providers and leaders emphasized the need to create more interventions rooted in Indigenous ways of knowing and being in order to heal trauma caused by historical and current colonialism that leads to these injuries.

⁷⁵ The Representative has released reports in recent years that address the need for these services. See: Representative for Children and Youth, *Time to Listen: Youth Voices on Substance Use* (Victoria, B.C.: Representative for Children and Youth), 2018, <https://rcybc.ca/reports-and-publications/reports/reviews-and-investigations/time-to-listen-youth-voices-on-substance-use/>.

See also: Representative for Children and Youth, *Youth Substance Use Services in B.C. – An Update* (Victoria, B.C.: Representative for Children and Youth), 2020, <https://rcybc.ca/reports-and-publications/reports/monitoring-reports/youth-substance-use-services-in-b-c-an-update/>.

Urban Indigenous children and youth

This report also revealed different patterns of injuries for First Nations children and youth living in urban or rural contexts. Service providers emphasized the unique context of Urban Indigenous youth and the complexities of serving this population. Our review of care plans revealed that, of those 200 First Nations children and youth, 35 per cent belonged to First Nations from outside of B.C. Many of those First Nations were not involved in care planning. Often, these children and youth were living in urban centres. Service providers reiterated the challenges faced by Urban Indigenous youth in identity and recognition.

Transition planning for those aging out of care

Analysis of reported injuries revealed that they were more commonly reported for those aged 13 and older. Service providers and leaders expressed concern for the well-being of youth as they age into adulthood. They emphasized the importance of supportive informal connections (such as family and friends) for youth, particularly youth in care.

Agreements with Young Adults (AYA) is a financial support available to young adults who have been in care or on a YAG. AYA can help cover the cost of housing, tuition and other costs for those who are attending post-secondary school or vocational training. Again, funding challenges were noted, with AYA supports often being delivered “off the side of the desk” by service providers.

Lack of appropriate services for those with complex needs

Finally, our review of care plans revealed a high number of First Nations children and youth in care with diagnosed or suspected developmental and mental health needs. Leaders and service providers confirmed that this reflects their experiences. They expressed concern that there is a lack of robust supports for families of children and youth with complex needs. Lack of support for families can increase the likelihood of First Nations children and youth with complex needs being brought into care.

Inequity between the availability and accessibility of supports for non-Indigenous children, youth, and families, as compared to First Nations children, youth, and families was also reported. One example was given that, in the same geographic region, there was differential access to assessment for developmental concerns, such as ASD or FASD. The MCFD office in that location had funding to pay for private assessments so that children and youth did not have to be placed on long waitlists for assessments through the health authority or school district. Therefore, those children and youth diagnosed could access any CYSN and/or school supports for which they were eligible. However, the DAA in the same region did not have this funding so children and youth served by the DAA could only access assessments through the health authority or school district.

First Nations leaders and service providers were also interested in what services, policies, and practices currently exist that protect children and youth from injury. They recommend that the Representative explore these “bright spots” so that these can be expanded to support the most vulnerable children and youth.

The concerns raised by service providers and leaders here will be carried into the Representative’s future work. DAAs who serve solely urban populations shared concerns about not having access to the federal funding for prevention services ordered by the Canadian Human Rights Tribunal (CHRT). Not being able to access this funding limits the DAAs’ abilities to provide culturally safe and culturally rooted prevention services. These DAAs, along with several other DAAs who serve both urban- and community-

based populations, receive very little, if any, prevention-specific funding from the provincial government. These urban-serving DAAs expressed a need to have access to a needs-based funding formula similar to the needs-based federal funding ordered by the CHRT.

The Representative has committed to doing a follow-up to the 2017 report *Delegated Aboriginal Agencies: How resourcing affects service delivery* and will be reviewing the current funding availability and approaches that support First Nations, Métis and Inuit children and youth in B.C. This upcoming work will illuminate the bright spots and the challenges that still exist in ensuring all First Nations, Métis and Inuit children and youth are supported equitably and effectively.

A Commitment from the Representative for Children and Youth

The Representative recognizes and strongly supports the inherent right of Indigenous peoples to self-governance which intrinsically includes jurisdiction over child and family services. Sadly, critical injury and death reports for First Nations, Métis and Inuit children and youth remain disproportionately high and the results noted herein remain similar in current injury and death data. The Representative realizes that these descriptions present many questions and commits to using the data as a springboard for deeper and specific considerations to support better outcomes for Indigenous children, youth and their families. These questions will be canvassed with those with the most intimate knowledge of what is best for their children, youth and families; the communities, families, services providers, leadership groups and the young people themselves.

In response to the current report, First Nations leaders posed questions for future research, including:

- Is there a difference in the number and type of injuries reported for First Nations children and youth served by MCFD versus DAAs?
- Is there a difference in the number and type of injuries reported for those children and youth who have active family and/or community involvement in their lives and those who do not?
- What is working well to protect First Nations children and youth from harms, such as self-injury and injury inflicted by others?

The companion report to this one, *Invisible Children*, examined Métis-specific issues arising from critical injury and death reports, in alignment with concerns that were shared with the Representative by Métis leadership around the invisibility of Métis-specific descriptions and analyses of data. Concerns differ for different populations and a pan-Indigenous lens cannot and must not be applied. What remains true, however, is the fact that for all First Nations, Métis and Inuit children and youth living in B.C., we must continue to advocate for better supports and services to support the resumption of jurisdiction over child welfare and inherent Indigenous rights to self-determination.

This report reflects new ways of sharing information with service providers and political bodies that is grounded in RCY's 6 Rs; that is, respect, relevance, reciprocity, responsibility, relationships and repair, with particular attention to the intention to share information in a responsible way that is relevant to First Nations communities and their interests for their children and youth. The hope is that this data may support the ongoing call for funding for services and supports that are sustainable, predictable and necessary to address the substantive inequities that exist for Indigenous children, youth and their families. The Representative is grateful to leaders, service providers and community members for sharing their expertise and experiences.

Discussion

The Representative joins those who are calling for robust supports for Indigenous families to support keeping families together rather than removing children and youth for reasons often rooted in poverty. It is now time to follow the Truth and Reconciliation Commission's Call to Action number one, ii: to provide "adequate resources to enable Aboriginal communities and child welfare organizations to keep Aboriginal families together where it is safe to do so, and to keep children in culturally appropriate environments, regardless of where they reside."⁷⁶ It is hoped that with substantively equal child and family services, injury and death reports might significantly decline and the over-representation of Indigenous children and youth in this data and in the system might be redressed.

⁷⁶ Truth and Reconciliation Commission of Canada, *Truth and Reconciliation Commission of Canada: Calls to Action* (Winnipeg, MB: 2015), 1.

Appendix A: Methodologies

What follows describes the approaches the Representative’s research team was informed by in its work. Each researcher brought their own story to this work and each has been mindful of this as they engaged with this data. While data can appear sterile and less storied, the research team views this data as representing the sacred stories of the young people. It was the hope of the research team for this project to begin to understand these stories better, and to report in ways that do no further harm but rather, produce systemic change.

An Intersectional Approach to Understanding the Child Welfare System

Government ministries and organizations across Canada have historically and contemporarily upheld Eurocentric perspectives, practices and policies, which contribute to disparities in Indigenous child welfare. Similarly, in conducting past research on First Nations, Métis and Inuit communities, researchers and governments have too often utilized non-collaborative and authoritative approaches that have treated Indigenous people as “subjects” rather than forming partnerships in the spirit of collaboration. An Elder working with Marlene Brant Castellano said, “*If we have been researched to death ... maybe it’s time we started researching ourselves back to life.*”⁷⁷ With this in mind, Indigenous and non-Indigenous staff have worked together within RCY to describe and analyze the data for this report.

The term “intersectionality” was coined 30 years ago by Kimberlé Crenshaw, a Black American legal scholar in a paper detailing the court’s myopic view of discrimination and “*single-issue analyses that intersectionality challenges.*”⁷⁸ While specific definitions of intersectionality remain varied, intersectionality encompasses understanding individual identities and how they can and do converge resulting in significant negative impacts to how certain people are viewed, treated and judged. Crenshaw noticed that Black women could experience discrimination by way of being Black and female and intersectionality invites us to consider both issues and the combination of these.⁷⁹

Intersectional theory centres the experiences of an individual or social group, accounting for the impact of power and privilege in society, as well as the important role that historical factors play in forming these systems.⁸⁰ While intersectionality has primarily focused on connections between race, gender and class, there is an emerging body of research that aims to examine the multiple interactions between diverse positions of social identity, such as age, ethnicity, Indigeneity, sexuality, class and ability.⁸¹ Intersectional theory can reveal the role that colonial oppression plays in shaping the histories and current realities of Indigenous children, their families and their communities.

⁷⁷ Marlene Brant Castellano, “Ethics of Aboriginal Research,” *Journal of Aboriginal Health* 1, no.1 (2004): 98.

⁷⁸ Kimberlé Crenshaw, “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,” *University of Chicago Legal Forum* 1, Article 8 (1989): 149.

⁷⁹ Crenshaw, 149.

⁸⁰ Olena Hankivsky and Renée Cormier, *Intersectionality: Moving Women’s Health Research and Policy Forward* (Vancouver: Women’s Health Research Network), 2009, http://bcccewh.bc.ca/wp-content/uploads/2012/05/2009_IntersectionalityMovingwomenshealthresearchandpolicyforward.pdf.

⁸¹ Olena Hankivsky, Daniel Grace, Gemma Hunting, Melissa Giesbrecht, Alycia Fridkin, Sarah Rudrum, Olivier Ferlatte, and Natalie Clark, “An Intersectionality-Based Policy Analysis Framework: Critical Reflections on a Methodology for Advancing Equity,” *International Journal for Equity in Health* 13, (2014): 119-135.

Intersectionality also aligns with Kirkham and colleagues' notion of "situated vulnerability":

*"We have coined the phrase 'situated vulnerability' that does not essentialize groups as 'vulnerable populations.' Rather, we examine the contexts and conditions under which people are made vulnerable. This is not to undermine the suffering of those who have been disadvantaged but rather, to acknowledge that vulnerability is a social construct, created through the social conditions of people's lives, and not a fixed state of being, or 'ethnic trait.'"*⁸²

Thus, when considering injury and death reports through a strengths-based approach, there are opportunities to recognize resiliency among Indigenous children and youth, on both an individual and collective level. Situated vulnerability, as a lens, allows us to consider the structures and systems that make certain people vulnerable. It can also be argued that intersectionality inherently aligns with an Indigenous worldview, which understands health and wellness as holistic.⁸³

Wellness for Indigenous children and youth must be understood through systems and structures of ongoing colonialism, which centres racism and discrimination, cultural oppression and violence, through which pathways to negative outcomes are formed. Intersectionality and situated vulnerability are used within this report to provide a more comprehensive understanding of the root causes of disparities for Indigenous children and youth within the child welfare system.

Indigenous Research and the Use of Statistics

When data is used by Indigenous communities, it can be a powerful tool for systemic change. This has long been recognized by Indigenous scholars, leaders and communities. As Cindy Blackstock of the First Nations Child and Family Caring Society of Canada states, "*Indigenous peoples repeatedly call for disaggregated data describing their experiences to inform resource allocations and policy and practice change.*"⁸⁴ Additionally, the TRC Calls to Action include keeping data: "*We call upon the federal government, in collaboration with the provinces and territories, to prepare and publish annual reports on the number of Aboriginal children (First Nations, Inuit, and Métis) who are in care, compared with non-Aboriginal children, as well as the reasons for apprehension, the total spending on preventive and care services by child-welfare agencies, and the effectiveness of various interventions.*"⁸⁵

⁸² Sheryl Reimer Kirkham, Jennifer L. Baumbusch, Annette S. H. Schultz and Joan M. Anderson, "Knowledge Development and Evidence-Based Practice: Insights and Opportunities from a Postcolonial Feminist Perspective for Transformative Nursing Practice," *Advances in Nursing Science* 30, no. 1 (2007): 35.

⁸³ Natalie Clark, "Perseverance, Determination and Resistance: An Indigenous Intersectional-Based Policy Analysis of Violence in the Lives of Indigenous Girls," Institute for Intersectionality Research and Practice, Simon Fraser University: Vancouver, 2012, http://www.sfu.ca/iirp/documents/IBPA/7_Indigenous%20Girls_Clark%202012.pdf.

⁸⁴ Cindy Blackstock, "First Nations Children Count: An Indigenous Envelope for Quantitative Research," *First Peoples Child & Family Review* 5, no. 2 (2010): 66.

⁸⁵ Truth and Reconciliation Commission of Canada, *Truth and Reconciliation Commission of Canada: Calls to Action* (Winnipeg, 2015), 1.

When data is available, it tends to portray Indigenous peoples as defective or damaged.^{86, 87} These deficient views of Indigenous people are mirrored within child welfare practice, as they are often used to substantiate child welfare interventions, as evidenced through the disproportionate apprehension of Indigenous children from their families and communities.⁸⁸

The context of colonialism is often not discussed within individual stories of Indigenous children and youth, which place Indigenous peoples as the problem when removed from the systemic context. As Eve Tuck notes, “*Without the context of racism and colonization, all we’re left with is the damage, and this makes our stories vulnerable to pathologizing analyses.*”⁸⁹ Additionally, Sandrina de Finney and Lara di Tomasso write about “*risk-centred*” rhetoric within social work, where children and youth within the system are described as “*‘broken’ and ‘lost causes’ who lack social skills and resilience, are unable to form healthy attachments, and are deviant, untrustworthy, or dangerous.*”⁹⁰ These deficit-based generalizations shape ways in which children and youth are perceived by others, as well as how the youth see themselves.⁹¹

When rooted in Indigenous ways of knowing, statistics can be used to tell stories via empirical representations that are reflective of Indigenous peoples and communities. In this report, the Representative aims to honour Indigenous ways of knowing by shifting toward reporting data in a more respectful and reciprocal way.

⁸⁶ Maggie Walter and Chris Andersen, *Indigenous Statistics: A Quantitative Research Methodology* (New York: Routledge, 2013), 16.

⁸⁷ Eve Tuck, “Suspending Damage: A Letter to Communities,” *Harvard Educational Review* 79, no. 3 (2009): 415.

⁸⁸ Holly A. McKenzie, Colleen Varcoe, Annette J. Browne, and Linda Day, “Disrupting the Continuities among Residential Schools, the Sixties Scoop, and Child Welfare: An Analysis of Colonial and Neocolonial Discourses,” *The International Indigenous Policy Journal* 7, no. 2 (2016): 1-24.

⁸⁹ Tuck, 415.

⁹⁰ Sandrina de Finney and Lara di Tomasso, “Creating Places of Belonging: Expanding Notions of Permanency with Indigenous Youth in Care,” *First Peoples Child & Family Review* 10, no. 1 (2015), 68.

⁹¹ de Finney and di Tomasso, 65-85.

Appendix B: Methods

Reporting Critical Injuries and Deaths to the Representative

Reviewable services are those provided under the *Child, Family and Community Service Act*, the *Youth Justice Act*, mental health services and addiction services.^{92,93} The Representative has a mandate to review all critical injuries and deaths of children and youth who are (a) receiving reviewable services, (b) have received reviewable services within the 12 months prior to the critical injury or death, and (c) whose families are receiving or were receiving reviewable services within the 12 months prior to the injury or death (e.g., family support services).

To this end, the *RCY Act* directs reviewable service providers to report all critical injuries and deaths for the above-mentioned population. Under the *RCY Act*, a critical injury is defined as one that results in, or has the potential to cause, serious or long-term impairment. Serious or long-term impairment is when an injury has prevented a child or youth from carrying out their usual day-to-day activities – or could in the future – or when the child or youth requires or could require considerable support to carry out their usual day-to-day activities as a result of the injury. This is interpreted to include physical and emotional injuries. For example, a child or youth who loses a parent by way of an overdose would be considered to have experienced an emotional injury.

The majority of injury and death reports are submitted to the Representative by MCFD. MCFD policy for reporting injuries differs for those children and youth who are in care and those who are not in care but are receiving services. For those not in care, injuries that result in, or that have the potential to result in, serious impairment (i.e., as a result of the injury a child or youth is unable to carry out activities of daily living or requires considerable support to carry out activities of daily living) are reported. These are also reported for children in care. Additionally, serious incidents are reported for children in care. Serious incidents occur when a child or youth is:

- lost or missing
- witness to, or otherwise involved in, another person's critical injury or death
- diagnosed with a life-threatening illness
- the subject of a report of abuse or neglect by a caregiver or in a care facility
- involved in high risk behavior.

Additionally, for those children in care for whom the Public Guardian and Trustee is their property guardian, practitioners must also report occasions when a child or youth is:

- involved in a motor vehicle accident
- involved in any event which may mean that a child or youth could be sued, charged with an offense and/or entitled to compensation for a loss or an injury
- involved in other circumstances of a similar, serious nature.

⁹² These include the three service areas of MCFD: child protection, Child and Youth Mental Health and Children and Youth with Special Needs.

⁹³ *Representative for Children and Youth Act*, SBC 2006, c. 29.

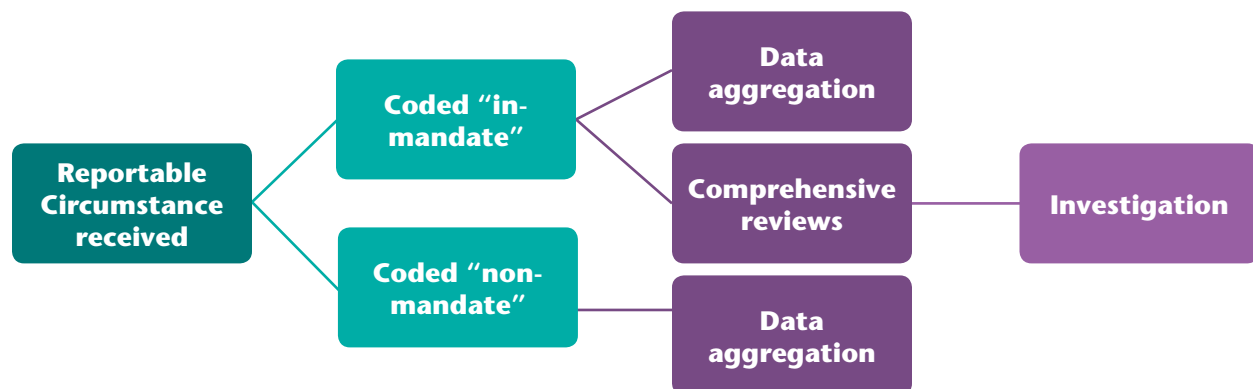
Because of the difference in reporting practices for children and youth who are in and out of care, it is not possible to compare the number of injury reports received. Any fatality of a child or youth receiving MCFD services, whether that child is in or out of care, is reported.

Injury and Death Data at RCY

Critical injuries or deaths are reported to the Representative using a reportable circumstance form (RC) that is completed and submitted electronically. Reports include a youth's demographic information (e.g., birth date, gender, Indigenous Nation), location (e.g., where the child or youth was living, where the child or youth was injured, where the child or youth receives services), living arrangement at the time of injury (e.g., family home, foster home), the reviewable services involved with the child or youth (e.g., child protection, mental health services, etc.), the child or youth's history of services (e.g., date at which services became involved and for what reasons), a description of the injury or death and the response of the service providers (e.g., a safety plan is developed for a youth who expresses suicidal ideation).

When injury reports are received by the Representative, the information related to an injury is entered into RCY's case management system. Analysts conduct an initial review to determine whether reports meet the Representative's mandate under the *RCY Act*.

Appendix B Figure 1: Pathway of reportable circumstances for research⁹⁴



As part of the initial review, analysts examine the incident description and code the injury into one of nine categories, or death into one of five categories, based on the description provided (see Appendix D for all definitions). A review of relevant records in MCFD's electronic system, ICM, is also conducted.⁹⁵ Operational definitions are followed for coding to increase reliability and validity.⁹⁶ For the current analysis, injuries were also classified according to perpetrator type. Injuries were classified as perpetrated on children and youth by others, inflicted by the child or youth themselves or unintentional.

⁹⁴ The Representative's staff can also take immediate action when needed, based on the information in an injury report. A child or youth may be referred to an RCY advocate or the case may be brought to the attention of the Provincial Director of Child Welfare.

⁹⁵ An initial review of electronic records includes case opening and/or closing recording, relevant case notes, relevant memos, incidents and service requests, and the care plan (for those children and youth in care).

⁹⁶ In this case, "reliability" refers to the chances that the same injury will be coded the same way by different raters and "validity" refers to chance that an injury is correctly coded.

Those who experienced injuries or deaths were also described. Gender included female, male and gender diverse. Age of those injured was also categorized as infant (less than one-year-old), toddler (ages one- to five-years-old), children (ages six- to 12-years-old) and youth (ages 13- to 18-years-old). Those who were injured were also categorized as in the care of MCFD (in care) or accessing another reviewable service (out of care). Legal status of those who were injured was also described. The child or youth's living arrangement at time of injury was also described for this data set.

Analyses

In this report, quantitative data from mandate reportable circumstances were described and analyzed. Differences were noted to be statistically significant at 0.05, which means that there is less than five per cent likelihood that the results occurred by chance. When differences were significant, an asterisk (*) is used in the charts to denote this. Analyses were limited to in-mandate injury and death reports.⁹⁷

Analysis of electronic records

MCFD and DAAs typically use ICM to manage the cases of children, youth and families who receive reviewable services. ICM has been used almost exclusively by MCFD and the DAAs since April 1, 2012. Some DAAs use a different electronic system, *Best Practices*, for similar purposes. In addition to this, practitioners often keep paper (physical) files for their children, youth and families. Generally, important documents are uploaded to ICM and are reviewed by RCY staff when an injury or death is reported. In some cases, electronic records are not reviewed as they are not uploaded or are in the physical file. ICM contains several electronic records including, but not limited to: legal agreements, location of child's residence over time, Care Plans, safety plans, incident reports, reportable circumstances, running case notes, risk assessments and psycho-educational assessments. The electronic Care Plan form is populated by the practitioner and can contain very useful information for the reviewer when an injury or death is reported. This information can include:

- Mental health concerns/diagnoses
- Developmental/physical health concerns
- Indigenous identity
- Religious affiliation
- Number of placements
- Significant life events
- School enrolment and attendance for school-age children and youth
- Family, extended family and significant relationships
- Cultural planning
- Transition planning for youth approaching the age of majority (i.e., those ages 17 to 19)⁹⁷

A Care Plan is prepared by a child or youth's social worker in a collaborative process involving the child or youth, family, community members and often professionals from community-based organizations. The goal is to improve the outcomes for children and youth in care in important areas of their lives, including health, education and independence. Strengthening relationships to traditional community and culture is also a critical function of care planning for Indigenous children and youth. An analysis of the electronic record was conducted for a stratified random sample of First Nations children and youth with reported injuries.

⁹⁷ Data on out-of-mandate injuries was captured starting September 2017 and will be considered in future analyses.

⁹⁸ The age of majority is 19 in B.C.

Limitations

The Representative acknowledges that there are limitations to this type of research. First, focusing on injuries and deaths ignores instances in which children and youth were kept safe and may produce a blame culture in which social workers or service providers become the focus of intense scrutiny thereby removing the focus from systems and structures that uphold and reproduce circumstances of situated vulnerability.

This study is also based on administrative data, and thus privileges the voices of service providers, rather than those of children, families and communities. MCFD reporting policy is different for children and youth in care, as opposed to children and youth receiving other services. The threshold for considering an injury serious enough to report is lower for children in care than for those out of care. Therefore, the Representative is unable to compare rates of injury between those in and out of care.

Lastly, there may be variation with reporting compliance by region and service stream, which may impact the results presented in this report.

The Representative's process for consultation with community in projects such as this is a new one. The Representative recognizes limitations in the process undertaken currently. For example, community leaders and service providers were not engaged in the initial project genesis but were consulted after the initial descriptive analyses were conducted. The Representative is appreciative of the time and expertise that was shared and looks forward to increased engagement with community in future research projects. Also, the Representative recognizes that not all community stakeholders were involved in the current consultations. In the future, it may be possible to include caregivers, Elders and other invested community members.

This report is limited to the First Nations children and youth who were connected to at least one reviewable service and who were critically injured or died, as reported within a three-year period. In this way, this data is not representative of all First Nations children and youth in the province. Further, analysts relied on coding of Indigeneity of children and youth available on ICM. While analysts conducted a thorough search of ICM for indicators of youths' self-professed identity, it is impossible to determine the accuracy of coding. Further, the data management system used by the Representative is only equipped to recognize one unique identity (i.e., First Nations or Métis), while children may inherently hold more than one identity.

Finally, this report privileges practitioner voice over youth voice as all reports of injuries and deaths were submitted by practitioners. While analysts read reports carefully to determine a youth's perspective on an injury (e.g., in a report in which a youth ingested substances, analysts examine the incident description to determine whether this was a substance-related injury or a suicide attempt), this is not always included in the report. The Representative will explore youth voice in subsequent projects but recognized value in a preliminary, descriptive analysis of injuries and deaths.

Youth engagement and youth perspective is vital to understanding and gauging the effectiveness of services that youth receive from MCFD and various other agencies. The injury and death reports that the Representative receives are written by practitioners detailing their perspective on the child, youth or family's life as well as the response to the injury. Very rarely is youth voice captured or youth perspective considered. Although child, youth and family perspectives and voices are not reflected in this report, the Representative has presented youth perspectives in RCY's *Time to Listen* report on youth substance use and a recent report by Katherine McParland on youth homelessness in B.C. and will be centring child, youth and family perspectives in upcoming reports. As services evolve and jurisdiction is established, these perspectives will be extremely valuable.

Appendix C: Number of Injuries by Type and Legal Status

| | Sexualized Violence | Suicide Attempt | Physical Assault | Substance-Related Injury | Accidental Injury | Self-Harm Injury | Caregiver Mistreatment | Emotional Harm | Total |
|----------------------------|---------------------|-----------------|------------------|--------------------------|-------------------|------------------|------------------------|----------------|------------|
| CCO | | | | | | | | | |
| First Nations | 179 | 88 | 99 | 85 | 37 | 38 | 47 | 31 | 604 |
| Non-Indigenous | 63 | 33 | 27 | 37 | 20 | 15 | 14 | 12 | 221 |
| Total | 242 | 121 | 126 | 122 | 57 | 53 | 61 | 43 | 825 |
| Family Guardianship | | | | | | | | | |
| First Nations | 13 | 23 | 20 | 19 | 12 | 11 | 0 | 22 | 120 |
| Non-Indigenous | 20 | 43 | 21 | 33 | 18 | 7 | 0 | 22 | 164 |
| Total | 33 | 66 | 41 | 52 | 30 | 18 | 0 | 44 | 284 |
| VCA | | | | | | | | | |
| First Nations | 20 | 14 | 5 | 16 | 4 | 5 | 1 | 1 | 66 |
| Non-Indigenous | 35 | 17 | 7 | 17 | 4 | 9 | 7 | 1 | 97 |
| Total | 55 | 31 | 12 | 33 | 8 | 14 | 8 | 2 | 163 |
| SNA | | | | | | | | | |
| First Nations | 2 | 13 | 3 | 1 | 2 | 2 | 3 | 0 | 26 |
| Non-Indigenous | 13 | 13 | 7 | 3 | 7 | 6 | 6 | 1 | 56 |
| Total | 15 | 26 | 10 | 4 | 9 | 8 | 9 | 1 | 82 |
| YAG | | | | | | | | | |
| First Nations | 3 | 6 | 7 | 3 | 2 | 7 | 0 | 0 | 28 |
| Non-Indigenous | 11 | 8 | 8 | 3 | 4 | 1 | 0 | 1 | 36 |
| Total | 14 | 14 | 15 | 6 | 6 | 8 | 0 | 1 | 64 |

The above table provides an overview of injury types for those legal statuses with differences across Indigeneity. Sexualized violence injuries were most commonly reported for children and youth who were CCO. A higher number of sexualized violence injuries were reported for First Nations children and youth than for non-Indigenous children and youth. However, the proportion of total injuries was equivalent for First Nations children and youth (30 per cent) and non-Indigenous children and youth (28 per cent) who were CCO. For those in the guardianship of family, in care via VCA or SNA, and supported by YAG, more sexualized violence injuries were reported for non-Indigenous than First Nations children and youth. Notably, sexualized violence injuries were reported significantly less than expected for First Nations children and youth living with family. Only two sexualized violence injuries were reported for those First Nations youth in care via SNA and three were reported for those supported by YAG. In contrast, 13 sexualized violence injuries were reported for non-Indigenous youth in care via SNA and 11 were reported for those supported by YAG.

Suicide attempts were reported more commonly for First Nations youth in care via CCO than non-Indigenous youth in care via CCO. For other legal statuses, suicide attempts were reported less commonly than for non-Indigenous youth. This pattern of injury was the same for physical assault and substance-related injuries as well.

Appendix D: Glossary

Injury and Death Categories and Definitions

| Injury category | Definition |
|-----------------------------------|--|
| Sexualized violence | Includes abuse (e.g., sexual acts committed against a child or youth by a person in a position of trust or authority), exploitation (e.g., child or youth exchanges sexual acts for food, shelter, illicit substances, protection, life necessities and/or money), assault (e.g., non-consensual sexual act perpetrated on a child or youth) and misconduct (e.g., non-touching and non-consensual sexual acts, including collection and distribution of images, exposing a child or youth to sexual images, or sexual harassment) |
| Suicide attempt | Non-fatal attempt to take one's life with the intent to die |
| Substance-related injuries | Non-fatal and accidental drug (illicit or prescription) overdose or alcohol intoxication severe enough to cause injury (e.g., vomiting, unconsciousness) |
| Physical assault | Physical injury that is serious or has the potential for long-term impairment (e.g., concussion, wound requiring stitches) that is intentionally inflicted by another person |
| Caregiver mistreatment | Inappropriate use of physical discipline and/or behaviour management methods (e.g., use of chemical or physical restraints, withholding food or using isolation to change behaviour), physical or sexual abuse by a caregiver, emotional abuse by a caregiver (e.g., taunting, belittling, name-calling, threats) or neglect by a caregiver (e.g., failing to seek required medical treatment or follow through with physician recommendations, inadequate supervision, domestic violence in the child or youth's presence, permission of drug or alcohol use by the child or youth) |
| Accidental injuries | Accidental in nature (e.g., injuries due to sports or recreation, falls, motor vehicle collisions) that result in physical injuries that are serious or have the potential to result in long-term impairment (e.g., broken, fractured, or dislocated bones, concussion, stitches and serious burns) |
| Self-harm injuries | Injuries inflicted on oneself that are serious or have the potential for long-term impairment and are carried out deliberately (e.g., wounds from cutting that require stitches or wounds from burning that require dressings) |
| Emotional harm | Experiences (e.g., witnessing another's death, being present during an episode of domestic violence, threats to physical safety) causing or likely to cause serious or long-term emotional impairment (e.g., a child or youth is afraid to leave their house, avoids certain people or situations or experiences trauma symptoms). |
| Death category | Description |
| Expected | When a child/youth dies by natural causes – this is often due to mitigating medical factors, such as a terminal illness or congenital birth defects |
| Accidental | The death of a child/youth as a result of an accident, by means other than natural death, homicide or suicide |
| Suicide | The deliberate, intentional taking of one's own life – this is a death caused by self-inflicted illness or injury |
| Homicide | When a child/youth's life is intentionally taken by another human being |
| Undetermined | A death in which the coroner cannot determine how the child/youth died – this may be due to lack of information, an ongoing investigation or equal evidence towards multiple possible causes of death (e.g., it may not be clear if the death was accidental or a homicide, or accidental or a suicide.) |

Delegated Aboriginal Agencies (DAAs) and Delegation Levels

DAAs have authority, from the Provincial Director of Child Welfare to administer all or part of the *CFCS Act* for Indigenous communities by way of delegation agreements. There are varying levels of responsibility under these delegation agreements that can be undertaken by a DAA. These levels are detailed below.

| Delegation Matrix | |
|-------------------|---|
| Level | Services Covered |
| C3 | Resource development and voluntary service delivery |
| C4 | Guardianship services for continuing custody wards |
| C6 | Full child protection services |

Children in Care

Legal Status of Those Who Were Injured

| In care | |
|---------------------------------------|--|
| Legal status | Description |
| Under removal (removal) | A child who has been removed from their parents' care due to concerns for their safety prior to a custody order being granted |
| Interim Custody Order (ICO) | An order placing a child in the custody of MCFD for 45 days |
| Temporary Custody Order (TCO) | An order placing a child in the custody of MCFD for a specified time period |
| Continuing Custody Order (CCO) | A permanent order under the <i>CFCS Act</i> placing a child in the custody of MCFD until age 19 |
| Special Needs Agreement (SNA) | An agreement between the guardian of a child and MCFD in which MCFD assumes care of the child but not custody. The intent is to provide services and supports for children with special needs |
| Voluntary Care Agreement (VCA) | An agreement between the guardian of a child and MCFD when a parent is temporarily unable to look after a child in the family home in which MCFD assumes care of the child, but not guardianship |
| Out of care | |
| Family Guardianship | Children who are under the guardianship of family and live with family (but access reviewable services). This can include children who are in the care of their family but whose care is supervised by MCFD, children living with extended family and children who are in the permanent custody of a person other than their parents |
| Youth Agreement (YAG) | Provides assistance to youth ages 16- to 18-years-old when a youth cannot remain in their family home. The youth is not in the care of MCFD but MCFD provides financial assistance and works with the youth to create a plan for independence |

Living Arrangement at Time of Injury

| Living arrangement | Description |
|---------------------------------|--|
| Family home | This can include living with biological (immediate or extended) or adoptive family members |
| Foster home | A home for children and youth in care that is family-based and in which foster parents are directly recruited, assessed, approved and supported by MCFD staff |
| Staffed resource | Contracted, agency-based placements that include residences such as group homes and shelters but also include contracted family-based care models of residential services where, for example, agencies recruit, train and provide ongoing support to the family-based caregivers and the child or youth through supplementary staffing and programming |
| Custody centre (custody) | There are two youth custody centres in B.C. that accommodate youth serving a custodial sentence as well as youth detained in custody pending trial or sentencing |
| No fixed placement | Those staying with friends on an informal basis, who are homeless, or whose living situation at the time of injury is unknown |
| Living independently | A youth who lives on their own with support from MCFD |
| Hospital | A child or youth may stay in a hospital for an extended period of time for physical (e.g., hospice service) or mental health reasons (e.g., inpatient psychiatric treatment or detox from substances) |

Developmental Health Concerns

ADHD is defined as a persistent pattern of inattention and/or hyperactivity and impulsivity that interferes with daily function or development. Prevalence in child populations is estimated to be as high as five per cent.⁹⁹

FASD is an umbrella term for a group of conditions associated with prenatal alcohol exposure. FASD is characterized by difficulties with thinking and memory, behaviour challenges and challenges completing activities of daily living. In Canada, it is estimated that four per cent of the population has FASD.¹⁰⁰

Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction, as well as restricted and repetitive patterns of behaviour, interests or activities with symptoms displayed from a young age. Rates of ASD are estimated to be as high as two per cent of the general population.¹⁰¹

Mental Health Concerns

Anxiety disorders are characterized by imminent fear and anticipation of future danger that is excessive or developmentally inappropriate. Anxiety may be general, related to a specific fear (e.g., separation from family or phobia) and can include panic attacks. Although not included in the anxiety disorders in the DSM-V, obsessive-compulsive disorder was included in this report's operational definition of anxiety.

There are a number of depressive disorders that are recognized but they are all characterized by sad or irritable mood that is accompanied by somatic (e.g., body aches, fatigue) and cognitive (e.g., memory problems, inability to concentrate) changes that negatively impact daily function. The estimated prevalence in the general population can be as high as seven per cent and is diagnosed more frequently in females than males.¹⁰²

PTSD occurs when an individual is exposed to or witnesses trauma that results in recurrent, involuntary and intrusive distressing memories of the trauma, recurrent distressing dreams related to the trauma, feeling or acting as though the trauma were happening again when it is not, persistent avoidance of places or situations that are associated with the trauma, negative changes in thinking or mood beginning or worsening after the trauma and marked changes in arousal (e.g., irritability or recklessness) when reminded of the trauma. All of these symptoms last for longer than one month and cause significant impairment in important areas of functioning (e.g., child is unable to attend school or stops spending time with friends). Lifetime prevalence of PTSD is estimated at slightly more than eight per cent and PTSD is more likely to be diagnosed in females.¹⁰³

Psychotic disorders, such as schizophrenia, are defined by marked abnormalities in five dimensions: delusions (e.g., fixed beliefs that are not changed, even in light of evidence that the beliefs are untrue,

⁹⁹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013), 59-65.

¹⁰⁰ Canada FASD Research Network, 2016-2017 Annual Report, accessed July 31, 2020, https://canfasd.ca/wp-content/uploads/2017/07/CanFASD_AnnRpt_2017_WEB.pdf.

¹⁰¹ Centers for Disease Control and Prevention, "Autism Spectrum Disorder (ASD)," Centers for Disease Control and Prevention, last reviewed November 15, 2018, <https://www.cdc.gov/ncbddd/autism/data.html>.

¹⁰² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 155-188.

¹⁰³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 271-280.

Appendix D: Glossary

such as a belief that one can control the thoughts of others), hallucinations (e.g., perception-like experiences that exist without actual, external stimuli, such as hearing voices in an empty room), disorganized thinking (e.g., switching from one topic to another, providing answers that are unrelated to a question that has been asked or speech that is so disorganized it may be incomprehensible), grossly disorganized or abnormal motor behaviour (e.g., strange behaviour that ranges from childlike silliness to agitation, to a rigid or bizarre posture) and negative symptoms (e.g., loss of pleasure in previously enjoyed activities, reduction in the amount a person speaks, reduction in the range of emotions shown by a person). Schizophrenia has an estimated prevalence of less than one per cent of the general population.¹⁰⁴

Eating disorders are characterized by a long-standing disturbance of eating behaviour that results in the altered consumption (e.g., restricting the amount of food eaten, as in anorexia nervosa) or absorption (e.g., causing oneself to vomit or using laxatives so that food that is consumed is not absorbed by the body, as in bulimia nervosa). Eating disorders occur in approximately one per cent of the general population.¹⁰⁵

Bipolar disorder is characterized by mood swings from low (similar to depressive symptoms) to high mood (also known as manic mood). The rate of bipolar disorder in the general population is estimated at two per cent.¹⁰⁶

A personality disorder is an enduring pattern of feeling and behaviour that is very different from cultural norms, is pervasive and inflexible and leads to distress or impairment. Borderline personality disorder is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, emotion and impulsive behaviour. In the group of youth whose files were examined in this report, borderline personality disorder was most often identified if a youth had suspected or diagnosed personality disorder. Rates of personality disorder in the general population vary but are estimated at about six per cent outside of clinical settings.¹⁰⁷

¹⁰⁴American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 87-122.

¹⁰⁵American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 338-360.

¹⁰⁶American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorder*, 123-154.

¹⁰⁷American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 645-684.

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